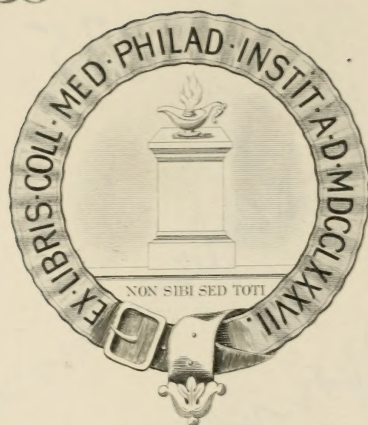




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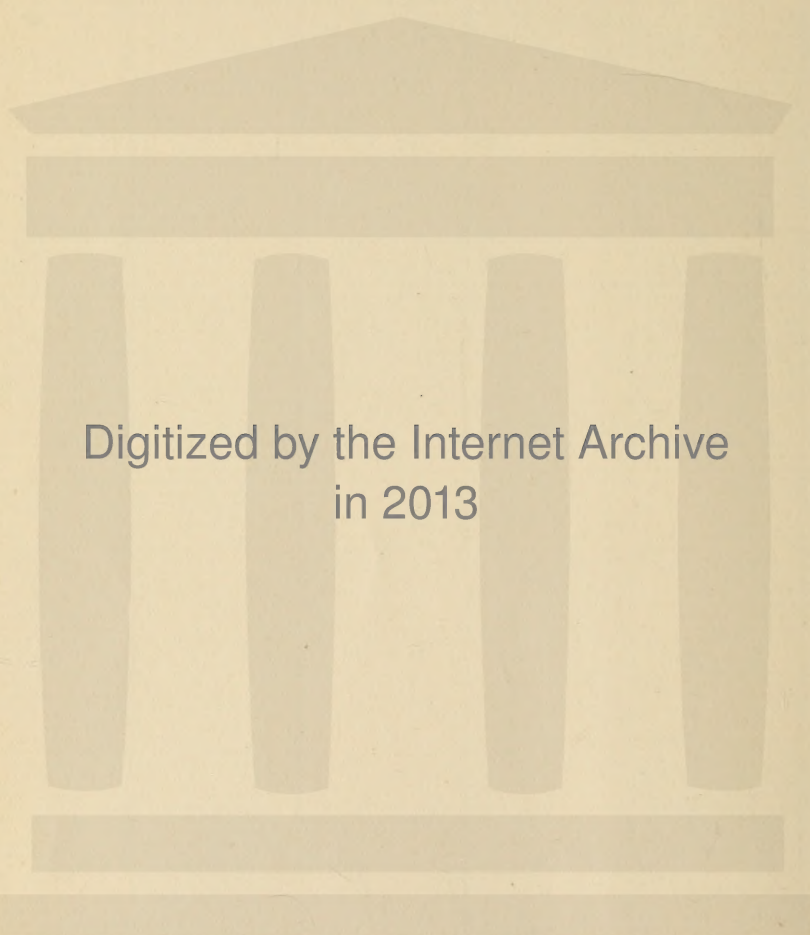


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EDITED BY
CLARENCE BARTLETT, M.D.

WITH THE COLLABORATION OF
WM. B. VAN LENNEP, A.M., M.D. WM. H. BIGLER, A.M., M.D.
WM. C. GOODENO, M.D. CHAS. M. THOMAS, M.D.

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JANUARY, 1902.

AUTO-INTOXICATION OR CONTRACTING KIDNEY.

BY CLIFFORD MITCHELL, M.D., CHICAGO.

ONE of the questions which frequently comes up is whether the patient has contracting kidney or simply auto-intoxication of intestinal origin. In the case of men, it is seldom that the answer cannot be soon given; but when the patient is a woman, greater difficulty is experienced in solving the problem. Take, for example, a case like the following one of many which the writer has seen:

Patient a woman, 45 years of age. Urine in 24 hours, 72 fl. oz.; night urine exceeds day; specific gravity, 1009; reaction, neutral; urea per 24 hours, 150 grains; phosphoric acid, 24 grains; uric acid, $3\frac{1}{2}$ grains; no albumin; no sugar; sediment of the usual epithelia; no casts; no crystals; no pus; no blood; no connective tissue.

More than one such case has been referred to the writer with the diagnosis of contracting kidney already made by the attending physician. Now, it is true that in contracting kidney we find urine of such quantitative composition; but, in the writer's experience, if the urine voided at different times in the 24 hours be carefully examined, either a trace of albumin or several hyaline casts per 15 c. c. of urine, or both, will be found, if it is really a case of contracting kidney. In the case above described no albumin and no casts could be found at any time of day. Furthermore, if no albumin or casts can be found

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after the patient has eaten as heartily as possible of meat, and has also been subjected to the test of as severe exercise as possible, then the presence of contracting kidney becomes improbable, especially if cardio-vascular and retinal changes are absent.

It will not be out of place here for the writer to inveigh against the too frequent practice of testing only the urine voided on rising in the morning. If the patient is merely told to bring a sample of urine for examination without further directions, the chances are very great that he, and especially she, will bring the urine voided on rising in the morning, which, even in well-advanced cases of contracting kidney, may contain neither albumin nor casts. A classical case of this kind the writer once saw with Dr. C. G. Fellows. After Dr. Fellows had made the diagnosis of retinitis albuminurica, and after careful examinations of the 24 hours' urine had shown the qualitative and quantitative indications of contracting kidney, the writer examined the urine voided on rising in the morning, and found nothing but a urine of poor quality, without either albumin or casts, and this, too, but a few weeks before death from typical uræmia. Mild, slow cases of contracting kidney are to be found in which albumin and casts may be absent in the forenoon. Such patients may in the earlier stages be accepted by life insurance examiners whose hours are early in the day. But the writer has yet to see a case of contracting kidney, or one which in a few months, at any rate, has developed into a recognizable case of contracting kidney, in which albumin or casts could not be found at some time in the day, especially after exercise or after hearty eating of meat. In men whose cases are at all doubtful it is the writer's habit to request the urine for examination to be collected during the 24 hours following a "stag" dinner or banquet. Any doubts about the case can usually be set at rest by examination of urine thus collected. The same may be said of urine voided after excessive sexual intercourse, with the observation, however, that such urine in the case of young men may contain albumin in small quantity (without casts or other evidences of renal lesion), probably referable merely to temporary renal congestion.

But to return to the case of women. Here the condition is

more puzzling. We find women with impaired health, unable to attend to their usual duties, occupations and pleasures, on the verge of nervous prostration, collapsing entirely in hot, humid weather, voiding a great quantity of pale urine at night, and not excreting 200 grains of urea in all during the 24 hours. Most careful examination of the urine fails to discover either albumin or casts at any time of day. Let it be understood, however, that the so-called delicate tests for albumin are excluded. The writer has shown, in an article in the *New York Medical Times*, that several of these tests (Spiegler's and the trichloroacetic especially) are subject to grave error from presence of alkaline carbonates. Now, it is in just such urine as that voided by women described above that we can find a white ring with some of these delicate tests, due to presence of these same alkaline carbonates. Add to such urine 10 per cent. of its volume of an 80 per cent. solution of calcium chlorid (pure crystals), filter, test again, and there is no white ring to be found, because calcium carbonate has been precipitated and filtered off, and albumin is absent. When the writer refers to absence of albumin, it is understood that boiling, followed by cautious addition of acetic acid (50 per cent.) drop by drop, shows no readily perceptible haze, and the cold nitric acid test performed by means of the albumoscope shows no white ring at all at the juncture of the fluids against the black background.

Moreover, repeated microscopical examinations of the urinary sediment, with and without centrifugal sedimentation, reveal no casts, or, at most, not more than one small hyaline cast, occasionally found.

When such results are obtained by examination of the urine, and when evidences of cardio-vascular changes or retinal changes are absent and typical uræmic manifestations are lacking, how can we make a diagnosis of contracting kidney?

On the other hand, it is true that contracting kidney is a most mysterious and insidious malady, and that it requires no small courage to deny its existence in the case of any obscure ailment in a person over forty years of age. The writer, however, believes that in the case of women this lesion is not common. Hundreds of women with urine like that of the analysis described in the beginning of this article have presented themselves from time to time for examination, and the writer is

unable to recall a single case in which subsequent developments have shown indubitable proof of the presence of chronic renal lesion. Even supposing that a dozen of them have died of uræmia, unknown to the writer, this would be a small proportion compared with the number which the writer positively knows to be alive and still devoid of any tangible evidences of contracting kidney after a period of several years. There is no question whatever, so far as the writer's experience goes, that contracting kidney is as uncommon in women as it is common in men.

On the other hand, the frequency of ovarian and uterine diseases, constipation and fecal impaction, in the case of women, have much to do with the development of what used to be called "renal insufficiency." The observations of Lucas-Championnière on the influence of ovarian diseases on the excretion of urea in women have already been quoted by the writer ("Manual of Urinary Analysis," 1897, p. 82). The effect of fecal impaction on the urine is well shown by the following case: Patient a woman, 43 years old, on the verge of nervous prostration, without organic lesion so far as could be discovered. Examination of the urine revealed the following:

Total urine for 24 hours, 34 fl. oz.; night urine, 22 fl. oz.; day urine, 12 fl. oz.; specific gravity, 1014; total urea, 177 grains; total phosphoric acid, 19 grains; total uric acid, 1 grain; no albumin; no sugar.

Sediment: The usual vaginal epithelia; no casts; no crystals; no pus; no blood.

No albumin and no casts could be found in the urine of this patient at any time of day. Cardio-vascular and retinal changes were absent. Her extreme weakness, however, and tendency to collapse in hot, humid weather, bespoke some kind of toxæmia.

The writer refused to make a diagnosis of contracting kidney, and ordered vigorous colon flushing, which was most conscientiously done, and repeated until an immense mass of impacted feces was removed. Now, what was the result? After the colon flushing was over, examination of the 24 hours' urine showed the following changes:

Total urine, 26 fl. oz.; day urine, 16 fl. oz.; night urine, 10 fl. oz.; specific gravity, 1015; urea, 279 grains; phosphoric acid, 32 grains; uric acid, 1 grain. Otherwise as above.

This is not the first time the writer has seen a re-establishment of the normal excess of day urine over night and an increase in urea follow colon flushing and removal of impacted feces. The patient is still alive, fairly well, and shows no signs of contracting kidney. Further examinations of the urine show neither qualitative nor quantitative deviations from normal worth noticing. The last analysis, one year after the discovery and removal of the fecal impaction, showed three hundred grains of urea in the 24 hours' urine.

In answer, then, to the question, Have we a case of contracting kidney or not? the writer submits the following conclusions:

1. In the case of men over 40 voiding urine of poor quality, with night urine exceeding day, the presence of contracting kidney is exceedingly probable; and urine voided after banquets, exercise or sexual intercourse, is likely to confirm the probability by showing presence of albumin and casts. Later the presence of cardio-vascular or retinal changes confirms the diagnosis, in case these are absent in the beginning.

2. In the case of women over 40 voiding urine of poor quality, even if the night urine exceeds the day, the presence of contracting kidney is improbable if, as is so often the case, neither albumin nor casts can be found at any time of day—especially improbable if ovarian and uterine diseases are present, and where milk diet increases urea to normal. Contracting kidney can probably be excluded by the return of the urine to permanent normal quantitative conditions after flushing of the colon and removal of impacted feces, when also, of course, cardio-vascular or retinal changes are not to be found.

GALVANIC CURRENT IN GONORRHOEAL RHEUMATISM.—Dr. Mathieu, of Paris, in thirteen cases of quite severe gonorrhoeal arthritis, both with and without periarticular swelling, obtained good results with the galvanic current. About twenty to fifty milliamperes are applied through the joint, giving a sitting every day; on the first day, however, two, each sitting lasting about fifteen minutes. Improvement usually follows in two to three hours after the first application; the next day both the swelling and pain are considerably diminished. A restoration to a healthy state usually requires from two to six sittings, and that without muscular atrophy or ankylosis. The faradic current does not act as well.—*Centralblatt fuer Chirurgie*, No. 43, 1901. (Thermo-therapy has been highly lauded in gonorrhoeal arthritis.)

OPERATION UPON SPINA BIFIDA AND MENINGOCELE; TREPHINING FOR
FRACTURES OF THE SKULL, LEPTOMENINGITIS AND
HYDROCEPHALUS EXTERNUS.

BY H. L. NORTHROP, M.D.

(Read before the Tri-County Medical Society, West Chester, Pa., August, 1901, and the
Raue Medical Club, Altoona, Pa., September, 1901.)

THAT the practice of medicine implies many and grave responsibilities is universally acknowledged. It is often said, and truly, that the physician is the servant of the public. He is *pro bono publico*. He should also be *pro bono fraternitatis*; and yet how few physicians realize that they have any duty toward their medical brethren except that called forth by professional etiquette or personal friendship. How few appreciate the fact that medical knowledge is a compilation of experiences, observations and experiments; that the vast medical literature of to-day is a harvest garnered from the seed sown by the individual practitioner, who, in his humble but conscientious efforts, contributes, it may be, only a single thought or offers but an isolated suggestion. And yet how invaluable that thought may be! By its influence some department of the science of medicine may be completely revolutionized, or some grim disease-monster successfully grappled with and stamped out. How reluctant some of us are to publish our personal observations; how seldom we appear in public with our rich experiences. We selfishly or indifferently hide our light under the bushel; and we are not practicing medicine for the good of our fellow-man, but for the good of our own pocket, when we might just as well and should do both.

Scan the medical journals of to-day and note the large number of specialists among the list of contributors. It is only natural that such should be the case, for specialism is advancing by long, rapid strides; and yet I "will wager a crown" that these journal articles are read by only a few who are particularly interested in this or that line of work. To the general practitioner, the bulwark of the profession, they have but a passing interest. I would not lay myself open to criticism as

detracting one jot or tittle from the specialist's article, necessary and invaluable as it is; neither would I have the general practitioner crowded out from a public recognition which is his by priority and which he should make every effort to maintain. The pith of the matter is this, that the specialist and the general practitioner should appear at medical meetings and in print with equal frequency, and should endeavor to interest each other in subjects of mutual concern; for the well-informed specialist must have a knowledge of general medicine, and the "good, all-round doctor" must know the essentials of the different specialties.

The above preamble has been prompted by the attractive meeting of this, the Tri-County Medical Society, in June last, when two general practitioners presented papers—one on "Placenta Prævia," and the other on "Onanism." The pertinency of these two papers naturally elicited a lively discussion, and they should prove a stimulus to members of this Society whose turn to write is to come, as I trust they have to me, your guest to-day, to write upon a subject of mutual and practical interest.

While a portion of my paper is concerned in the report of cases somewhat out of the ordinary, I have endeavored to keep in mind the commendable example set by your June essayists, and make each of my hearers feel that this paper has been written for him individually. In the *HAHNEMANNIAN MONTHLY* for May, 1901, I described a case of spina bifida and outlined the plan of expectant treatment pursued up to the time of publication. As I have operated upon this patient since the writing of the article referred to, it is now *apropos* that I should follow the case further. The bifida at the lumbo-sacral junction of this eight-weeks-old baby increased in size, simultaneously with which a marked thinning of its walls occurred and spontaneous rupture seemed imminent. The child's general condition had improved greatly, and it was agreed that a radical cure should be attempted at once by operative interference.

On April 16th chloroform and oxygen was administered by Dr. J. W. Hassler, and after the most rigid preliminary toilet of the patient, of Dr. A. L. Foster (the attending physician), and of myself, I punctured the tumor and removed four ounces of normal cerebro-spinal fluid in fifteen minutes. A longi-

tudinal incision was then made, opening a cavity lined with smooth, modified dura, to which were attached six or eight poorly developed nerve trunks. These emerged from the slightly oval opening three-quarters of an inch in diameter, the deficiency in the posterior wall of the vertebral column.

After ligating the nerves close to this opening (the neck of the sac), I allowed them to retract into the neural canal. The serous lining was dissected loose for a sufficient distance around the opening and well into the opening, and closed tightly by a ligature of heavy cumolized catgut. The stump thus formed served as a plug to the opening in the bony wall, and filled it nicely. After removing a part of the now redundant sac on each side, I undermined the fatty and aponeurotic tissue forming the floor of the cavity laterally, and easily approximated the sides with catgut. The work was completed by a continuous silk suture of the overlying skin and the application of a bichloride dressing. Time of operation, forty minutes, including removal of cerebro-spinal fluid.

The child suffered moderately from shock, which, however, required no special treatment. Primary wound healing followed, and the general condition remained good until April 28th. Twelve days after the operation it was noticed that the lower extremities were limp and without voluntary motion. At the same time their surface temperature was lowered, and they presented a mottled appearance. Evidently a profound and apparently sudden change had occurred in the circulation and vitality of these extremities; in the fullest sense of the word, they were paralyzed. What should cause this complication twelve days after the operation is more than I can tell. Up to this time the child had kicked vigorously, and was apparently none the worse for the loss of its bifida. Now, the nerve supply to the lower extremities was completely cut off. Pressure from hæmorrhage or extravasation may have been to blame for it, or perhaps there was a late, deep infection, producing a myelitis. Had an infection occurred, however, I would have expected symptoms of meningitis, of which there were none. At no time was there any evidence of cerebral irritation or nerve disturbance of any other part. The child vomited frequently, failed rapidly, and died seventeen days after the operation and twelve weeks from its birth.

In contrast with the above case of lumbar meningocele, I will report one of occipital meningocele (Figs. 1 and 2), a patient of Dr. S. C. H. Schneider. This little girl, three years old, was born with a soft and fluctuating tumor, attached to the skull just above the external occipital protuberance. At times it was flabby, collapsed; at others its walls were tense and distended. This points unmistakably to an early communication with the cranial cavity, but not existing now, inasmuch as the size of the tumor is stationary and its contents cannot be displaced. Examination shows a pendulous, pyriform and pedunculated tumor dangling from the median line of the occipital bone just above its protuberance. Its longitudinal and transverse circumference is six inches in each direction; it fluctuates and transmits light perfectly. I amputated this meningocele, found the occipital bone without perforation, and then closed the wound with silk sutures. The result of this simple operation was, of course, a perfect success.

Only 8 per cent. of all meningoceles are pedunculated. Such cases usually have a small aperture in the bony wall of the cranio-vertebral axis. Spontaneous closure of this opening occurs in a small number of cases, constituting a most happy factor in bringing about a radical cure of an altogether too frequently incurable deformity.

The two cases just cited should be placed side by side, offering, as they do, good opportunity for comparison. One point to be emphasized is the gravity of that lesion which communicates with the neural canal or involves its contents. Another is the rarity of a pedunculated occipital meningocele and one without serious cerebral defect.

Neurological surgery certainly is fascinating, while none other necessitates the exercise of one's powers of resource more; none other calls forth the introductory sentiments of this paper more strongly, for neurological cases should be freely published and accurately described.

That the operation of trephining is not performed as frequently as it should be is a well-known fact, attested by many of the cases of epilepsy, imbecility, brain abscess and cyst, that come under the observation of the neurologist. The oft-applied phrase "compression of the brain" covers a multitude of sins (of omission), as well as much ignorance, and is time

FIG. 1.



FIG. 2.



and again responsible for the untoward sequelæ just enumerated. Its use, fortunately, is much more restricted than formerly. Some, perhaps many, cases of fissured or even slightly depressed fractures of the skull go unoperated upon, and no ill-effects ever appear; likewise, traumatic intracranial hæmorrhage may occur, and absorption, instead of cyst-formation, be the end of it. But such occasional coincidences offer the weakest kind of argument against exploration of the skull in suspicious cases and the application of the trephine when fracture may be present, or when peripheral or reflex evidence of intracranial damage exists. This principle of skull-fracture treatment cannot be made too emphatic, since the risk is so slight (practically *nil*) and incalculable immediate good may be done and untold future trouble prevented. While the result of trephining the skull for fracture is often brilliant, this operation performed in cases of intracranial disease is followed, at times, by results but little short of the miraculous. Remember that medicinal and adjuvant treatment must also be employed in cases of head injury and disease, but of these it is not my purpose to speak particularly.

In adding to the laurels already won by the trephine my contribution will consist of a few selected cases; selected because they exemplify the advisability (I would rather say the necessity) of exploring the skull wall in all cases of head injury where there is even a remote possibility of fracture existing, and also selected by reason of individual features of interest, or complications, and to show the value of saline infusion as a life-saving means.

CASE I.—C. S., male, age 18 years, was brought to Hahne-mann Hospital after having fallen thirty feet, striking on his head. He was unconscious and vomited stomach contents. There was no bleeding except from two small lacerated wounds in the left occipital neighborhood. Shortly after his admission he developed a typical, well-defined convulsion, made up of clonic movements of the left hand, forearm, arm and face, and, to a less degree, involving the left lower extremity. After his head had been shaved and he had been etherized, Dr. G. A. Van Lennep enlarged the scalp wound and found a fissured fracture four inches long in the occipital bone below the lambdoid suture, extending across the median line to the right.

Upon trephining above the fissure an extradural clot was discovered and removed. The feature of this case to which I wish to call attention is the convulsion. The occipital bone was fractured upon the left side, but a single, well-outlined convulsion of the *left* side of the body had occurred. This unmistakably (and beautifully) indicated disturbance of the *right* Rolandic area; but no fracture existed at that point, and the neurological explanation of this disturbance must be sought for in the *contre coup* theory. The force, or effect, of the left-sided occipital injury was transmitted to the right side of the head, causing sufficient irritation and contusion to produce the left-convulsion.

CASE II.—John D., age 6 years, fell from the roof of a third-story house and was brought to the Children's Hospital unconscious, with projectile vomiting and sluggish pupils. He had a large, broad hematoma over the left parietal bone, but no scalp wound—not even an abrasion. There was an epiphyseal separation at the upper end of the left humerus.

Under chloroform anæsthesia I made an incision into the hematoma, liberating liquid and clotted blood and numerous crumbs of brain matter. A fracture extended through the posterior two-thirds of the left parietal bone, one and one-half inches from and parallel to the superior longitudinal sinus. At the lambdoid suture the line of fracture turned abruptly to the right and entered the right parietal bone. The dura and brain had been badly lacerated, and the latter was caught and held by the fragments. The trephine was applied to the left parietal bone and a one-inch button removed. The boy's general condition, poor from the beginning, now necessitated infusion; so, hurriedly tacking the scalp flaps together with two silkworm sutures, I opened the right saphenous vein and infused three pints of hot saline water. Prompt improvement followed; and in two days chloroform was again given by Dr. Clover, the hospital anæsthetist, and the scalp wound opened. Although having removed but a one-inch button at the first operation, the separation in and mobility of the skull wall was sufficient to permit a large hernia cerebri of the left parietal lobe, posteriorly. This I freely amputated, removing an area of brain substance two inches long by one and one-half wide, and about three-eighths of an inch thick at its center. I concluded that

intracranial pressure had been more than sufficiently relieved and that further removal of bone would be unwise, only tending to aggravate the hernia. The scalp was therefore carefully sutured and an iodoform gauze drain introduced posteriorly. The wound healed per primam, though considerable cerebro-spinal fluid escaped at the drainage opening. Persistent, firm pressure was required to combat the hernia cerebri. This latter complication was entirely removed in less than two weeks, and the patient was discharged with a slight depression, instead of protrusion, over the trephined area. There was no mental impairment. This case would undoubtedly have been lost without saline infusion, and unless the operative work had been performed in two tempos.

CASE III.—Barbara F., age 3 years, fell from a third-story window and was brought to the Children's Hospital in an unconscious condition. She had typical, projectile vomiting of bile and stomach contents. The vomit was ejected with force, suddenly, and for a considerable distance. There was no bleeding from nose, ears or mouth, nor was there even an abrasion of the scalp. A moderate amount of swelling occupied the vertex, and a crater-like depression was present over the right frontal eminence. Her temperature was $101\frac{1}{3}^{\circ}$, pulse 88, respirations 24.

Five hours after the fall she was still unconscious. Chloroform was thereupon administered, and I opened the scalp over the left parietal bone. I found a fracture extending from the right frontal eminence backward into the sagittal suture, which it followed for two inches and then ran into the left parietal bone, with several small secondary fissures extending into the right parietal bone. The use of the trephine was not necessary. The abnormal mobility was so great that the rongeur forceps alone sufficed to remove the necessary amount of bone to relieve the intracranial pressure and to liberate the entangled, lacerated dura and left cerebral hemisphere. The two latter (dura and brain) had been caught between the bony flaps and badly torn. Many fragments of cortical matter were found under the scalp and in the line of fracture, and the superior longitudinal sinus had been opened just behind the coronal suture. Considerable hæmorrhage occurred from this sinus, necessitating an iodoform gauze pack. A large

extradural clot was found beneath the frontal bone, extending down to the floor of the anterior cerebral fossæ.

At the close of the operation the right saphenous vein had to be opened and infusion performed.

The gauze packed into the wound of the superior longitudinal sinus was removed very gradually and no secondary hæmorrhage occurred. The scalp wound healed throughout by first intention and the child was discharged eighteen days after admission.

This case illustrates the deceptive nature of a scalp swelling. The crater-like depression over the right frontal eminence suggested a depressed fracture at this point. The incision did expose a fracture here, but it was the narrowest kind of a fissure, without any depression whatsoever.

So little reliance can be placed upon traumatic irregularities of the scalp that it is the height of folly to believe that no depression of the skull exists unless it can be felt by the examining finger, or to say that there must be a bony depression when external palpation indicates it. It is a fact that the majority of skull fractures are not of the depressed variety, be they ever so extensive. On the other hand, many simple scalp contusions present depressions. Diagnosis of head injuries is often like diagnosis of abdominal lesions—you cannot be sure of existing conditions until you open and see.

CASE IV.—Fred G., age 10 years, was struck by a locomotive and was brought to the Children's Hospital. He was unconscious, his pupils were pin-point in size and did not react. He had projectile vomiting, and a stream of venous blood flowed from his left auditory canal. There was no wound of the scalp, but behind his left mastoid was a depression. His temperature was 97°, pulse 128, respirations 24.

Because of my absence from the city, Dr. Walter Strong was called and trephined the occipital bone below and behind the asterion. Upon the removal of the trephine button a gush of blood came from the lateral sinus. The boy collapsed, and the wound had to be quickly packed with gauze and pressure applied. His stupor continued after this operation, and he was restless and, at times, delirious. I prescribed hypericum, 3x; later, no improvement following, he received opium, 3x. On July 10th, six days after the injury, he was still unconscious,

so I opened the wound, and found the whole left temporal bone disarticulated and freely movable. Sequestrum forceps were used to remove a loose fragment of the occipital bone close to the mastoid, and rongeur forceps to bite away the squamous bone above. Upon removing the pack in the lateral sinus it bled fiercely, and I quickly introduced a strip of gauze under the lower angle of the parietal bone and closed the scalp wound. No hæmorrhage occurred after this. I loosened the pack and removed small portions of it every five or six days, consuming nearly three weeks in its entire removal. No infection of this drainage opening took place.

These two cases just cited are of especial interest because of the wounds of the venous sinuses of the cranium, and case 4, in addition, because of the long-continued unconsciousness, which was relieved only by the removal of large portions of the occipital and temporal bones.

The gauze-pack treatment of wounds of the cranial sinuses deserves attention, since it is the easiest and most effectual plan of controlling hæmorrhage from these securely protected vessels. Wharton* presents a list of seventy collected cases of wounds of the venous sinuses of the brain, and describes five methods by which hæmorrhage from these sinuses may be controlled. He concludes by stating that "the most satisfactory and generally available method of treatment consists in controlling the bleeding by aseptic gauze packing." As Wharton states, the chief risk lies in the introduction, or in the production, of septic material, thereby causing infection. But this will occur very infrequently in competent hands.

CASE V.—Wm. S., age 8 years, was struck on the head by an iron quoit. Although knocked down, he got up and walked more than a mile to the Children's Hospital. He was fully conscious, rational, without headache or other complaint, except that "his head felt like something pressing on it." There was a wound one inch long over the upper part of the right parietal region, and enlargement of this wound, with exploration of the skull, revealed a depressed fracture under the scalp above the laceration.

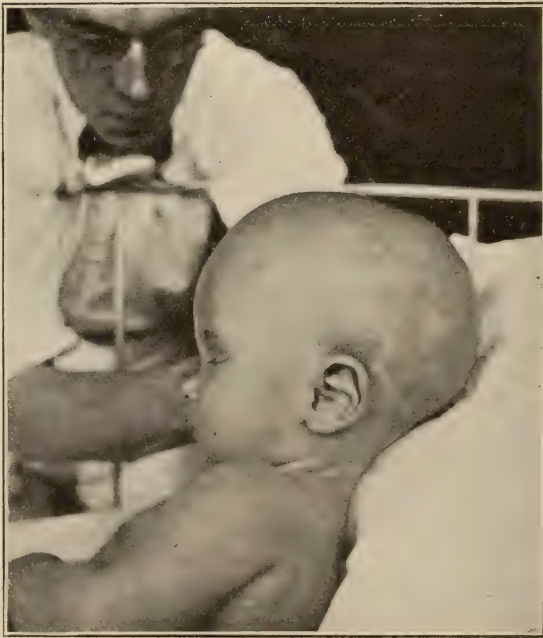
Under chloroform the fracture was found to be one and one-

* *Annals of Surgery*, July, 1901.

FIG. 3.



FIG. 4.



half inches long. The displaced bone was removed by trephine and rongeur forceps.

Here was a head injury without symptoms of fracture, subjective or objective. Exploration was necessary to reveal the true local condition, one that needed surgical attention.

CASE VI.—Ethel C., age 7 years, was admitted to the Children's Hospital with a history of epileptic seizures since she was three years old. There was no knowledge of accident or injury. Her parents are healthy, but her mother is highly neurotic. For three years her convulsions took place only at night, though for the past year they have occurred during the day also—as many as six or eight in twenty-four hours.

The onset of a convulsion was manifested by a tonic flexion of the right thumb and fingers, then of the hand and forearm, which was followed by twitching of the whole body, with the head thrown back, arms carried above the head, toes turned up, whole body rigid, frothing at the mouth, and eyes half closed. The seizures lasted from three to five minutes, and were followed by a sound sleep. While in the hospital she gave positive evidence of progressive mental degeneracy, and upon the advice of Dr. Tuller, the hospital neurologist, who had made a diagnosis of leptomeningitis, she was prepared for operation.

Under chloroform I mapped out the left fissure of Rolando and removed a trephine button just anterior to its middle third, to expose the motor centers governing the hand and forearm. After enlarging this opening to one and three-quarter inches by two and three-quarter inches, and turning back a flap of the dura, we applied a Faradic current by means of Keen's brain electrode, and reproduced her usual convulsion of the hand, forearm, etc. In corroboration of the diagnosis of chronic leptomeningitis, I found a thickened, œdematous, deeply injected pia mater, adherent to the dura. The skull wall was unusually thick and there was free diploic bleeding.

The dural flap was sutured with fine catgut, a small iodoform gauze drain was inserted and the scalp wound was closed.

Twenty-four hours after the operation a convulsion which was preceded by a slight elevation of temperature occurred. At the re-dressing the next day a small quantity of pus was expressed from the drainage opening. This convulsion was evidently caused by an infection of the wound, which, however,

amounted to nothing further, and the wound healed promptly and nicely. She is still in the hospital, two months after the operation, under general observation and treatment, has had only two slight epileptic seizures, about three weeks after the operation, and is a totally different child mentally. She talks freely and rationally, and takes an interest in what is going on around her; even the expression of her face is that of a different child. The improvement in her mental condition, not to forget the cessation of the convulsions, is a noteworthy fact. Although we prophesy nothing for this child's future, we claim a brilliant result, so far, for the intelligent use of the trephine.

CASE VII. (Figs. 3 and 4).—Jos. R., age 4 months, was admitted to the Children's Hospital with a good family history. When six weeks old his head began to increase in size rapidly and he developed a peculiar cry at night. His head, upon admission, measured seventeen inches in circumference, and the bones were thin and the sutures widely separated. A percussion wave was plainly transmitted from side to side, and the whole head gave a sensation of fluctuation. His mental state was one of profound depression; he had a bilateral nystagmus and lay in a half stupor, with eyes closed most of the time. Diagnosis, hydrocephalus externus.

Dr. Tuller advised operation for drainage, which I performed according to the method of Parkin. After turning back the soft tissues in the right occipital region I removed a button of bone eleven-sixteenths of an inch in diameter and one-sixteenth of an inch in its thickest portion. Part of this button was as thin as writing-paper, and semimembranous. By incising the dura I opened up the right cerebellar fossa and permitted an escape of cerebro-spinal fluid from beneath the cerebellum. Six ounces by measure were slowly removed, ten minutes being consumed in their withdrawal. The head now presented a smashed-egg-shell appearance. An iodoform gauze drain was introduced through the dural opening and the scalp was sutured around it. The child evidenced considerable shock at first, but rallied under the use of hot milk and brandy. The report of the examination of the fluid withdrawn is as follows: "Color, reddish yellow; cloudy; no sediment; no odor; reaction, alkaline; specific gravity, 1006; albumin, .125 per cent.

by weight; no sugar; few phosphates. Microscope shows blood-cells and a few leucocytes.

"S. W. SAPPINGTON, M.D.,

"Pathologist."

The cerebro-spinal fluid continued to escape freely for about three weeks, when the drainage opening became sealed and a simultaneous increase in the cranial measurements occurred. During this post-operative period, however, the facial expression, mental condition and general behavior of the child improved wonderfully. With the reaccumulation of the fluid and the renewal of the pressure, the old hydrocephalic symptoms returned and a second operation was agreed upon.

In performing this I enlarged the original opening in the dura, secured effectual drainage, and removed four ounces of fluid. It was my intention to make this drainage permanent, but, I regret to say, the child died four days after the operation.

I take pleasure in publicly acknowledging the valuable aid rendered by Dr. David Hardie, resident physician of the Children's Hospital, who worked faithfully and intelligently with the hospital cases; and by Dr. Samuel W. Sappington, who photographed the case of hydrocephalus.

TUBERCULOSIS OF LIVER.

BY RALPH J. ISZARD, M.D., NEW YORK.

(Read at a meeting of the Academy of Pathological Science of New York City, May 31, 1901.)

ON November 30, 1900, a patient (male) entered the Metropolitan Hospital, Blackwell's Island, New York City, complaining of shortness of breath, pain in the right side of the chest, and swelling of the feet, legs and abdomen, which had been increasing for the past five months.

He was a man forty-nine years of age, a native of Norway, and since coming to this country had worked as a longshoreman. His family history showed no hereditary diseases, and the only previous sickness that he remembered was an attack of pleurisy in 1899, when he was tapped seven times. He had always been a user of tobacco and alcoholics, principally beer,

and was a hard worker. Physical examination showed his body to be fairly well nourished, and of a rather sallow complexion. No particular puffiness was noticed about the eyes. The arcus senilis was well marked. The liver dulness extended an inch below the free border of the ribs and was rather tender. The abdomen was sensitive to pressure, greatly distended with fluid, and dulness, when standing, to a point above the umbilicus. The spleen was enlarged considerably. The lower extremities were cyanosed, cold and œdematous. Appetite was fair, bowels moved once a day or every other day, stools of normal color and consistency. The lungs were normal with the exception of the left apex, where there were dulness and bronchial breathing. The area of cardiac dulness was increased to the left, and also greatly to the right, the right border extending beyond the right edge of the sternum. A slight aortic stenosis was appreciable, and the action was rapid and rather weak.

The amount of urine was below normal (about thirty fluid-ounces), of light amber color, specific gravity 1022, and contained a trace of albumin.

The diagnosis of hypertrophic cirrhosis of the liver with consequent dilatation of the heart was made, notwithstanding the absence of gastric and intestinal symptoms and dilated abdominal veins.

The patient was confined to bed, being hardly able to raise himself to a sitting position. He was put on laurocerasus and slowly improved until in eight weeks he was walking about the ward. He continued in this condition, at times complaining of the abdominal tension and distress, which was greatly relieved by three tapplings at intervals, about 500 fluidounces being obtained in the three operations.

During the last six weeks he became greatly emaciated, his face sunken in and somewhat cyanosed, and the abdominal distention diminished while the dulness and pain increased.

About ten days before death he became much weaker and was confined to bed, complaining of abdominal pain and soreness and headache.

The last three days he became stupid, refused food, the pulse became weak and rapid, the face cyanosed, the lungs œdematous, and he died after a delirium of twenty-four hours. At

no time did the patient have any fever until the last three weeks, when the temperature ranged from 98° to 99° in the morning, and from 100° to 101° in the evening. The patient died May 21.

Autopsy.—The body was poorly nourished, rigor mortis pronounced, abdomen distended, tympanitic percussion note anteriorly with flatness in the flanks, the percussion note upon the cadaver over the cardiac area still indicating enlargement of heart to one inch to the right of the sternum.

Upon opening the body the visceral and parietal layers of the pericardium were found to be closely adherent and the heart bound to the pericardium by strong bands of adhesions. The heart itself was normal in size, but layer after layer of bands of adhesions had formed along the right of the pericardium which resulted in a solid mass one inch in diameter; this accounted for the increase of cardiac dulness; the heart was soft, contained no clotted blood; calcareous deposits were found about the aortic orifice, thus confirming the diagnosis of aortic stenosis.

The lungs proper were normal macroscopically, but were so closely adherent to the chest wall by pleuritic adhesions that it was impossible to remove them without lacerating the lungs, thus confirming the diagnosis of chronic pleurisy.

Upon opening the abdomen the peritoneum was found to be closely adherent to the abdominal wall, the intestines were matted together, the omentum, intestines, peritoneum and liver were covered with numerous minute nodules about the size of a grain of sand and larger. The liver was adherent to the diaphragm and enlarged to eighty-four ounces; the substance was toughened and gritty and fibrous tissue greatly increased; the spleen was enlarged to seventeen ounces, congested and pulp softened.

Very little ascitic fluid was found in the abdominal cavity although he had not been tapped for three months; this was accounted for by his having been on infusion of digitalis for three weeks, increasing his amount of urine, and as his heart's action had gradually been growing weaker, thus alleviating the intravenous pressure in the portal system resulting in a cessation of the exudate into the abdominal cavity, although the portal obstruction still remained.

Both kidneys were enlarged, weighing eight and one-half ounces, capsules slightly adherent, cortex pale and thickened, pyramids well defined and darker in color.

Now the question arose, What was this enormous liver, and had it any relation to the intestinal conditions? Was the ante-mortem diagnosis of hypertrophic cirrhosis of the liver correct? Was it an amyloid degeneration? Was it a malignant growth? Was it syphilitic, or was it tuberculosis of the liver?

Having a history of intemperance in the use of alcohol, it was strongly suggestive of cirrhosis, and had it been reduced in size with the enlarged spleen there could have been hardly any question as to the nature of the affection; then we must bear in mind that cirrhosis has certain resemblances to fatty or amyloid liver; but the presence of ascites, which is not a feature of waxy or fatty liver, and a history of the causes of cirrhosis are strong points in evidence, however.

Having been unable to obtain any specific history or symptoms, nor any intestinal symptoms, his being not particularly cachetic, no jaundice, the hypertrophy not progressive, the liver not irregularly enlarged, nor did it possess a hard nodular surface, hence the consideration of cancer, amyloid and syphilitic, can easily be excluded. Now, was it cirrhosis or tuberculosis?

Had it been cirrhosis the liver should have been enlarged, there should have been an increase in connective tissue with passive congestion, portal obstruction, ascites and enlargement of the spleen: these were demonstrated, but they are also common to tuberculosis of the liver; cirrhosis should also set up gastro-intestinal catarrh, hæmorrhage, pelvic congestion, more or less jaundice, hæmorrhoids, enlarged superficial veins and a nodular surface; these were not demonstrated, but minute granulations of bright yellow color were found upon the under surface and in the connective tissue of the liver.

Upon opening and curetting the interior and staining, it was found that they contained numerous tubercle bacilli; we felt justified in diagnosing the condition as tuberculosis of the liver, secondary to a general miliary tuberculosis; we also made a diagnosis of chronic pleurisy, aortic stenosis and chronic parenchymatous nephritis.

THE IODIDE OF ARSENIC AS A THERAPEUTIC AGENT, FROM MY
STANDPOINT: A PARTIAL STUDY.

BY EDWARD R. SNADER, PHILADELPHIA, PA.

My use of the iodide of arsenic therapeutically is altogether empirical. I personally know of no provings of the arsenic and iodine combined; and, if such exist, if they are as voluminous as provings usually are, I doubt if I could be tempted to read them. From past experience, I know that an attempted perusal would give me that tired feeling, the remedy for which would vary with the personal equation of the prescriber, from gelsemium or nux to Hood's sarsaparilla, the bicycle, or Swaboda's movements. If I use a drug empirically, I do not think it necessary to apologize for it. If I did so, I would be quarreling with the very foundation of all materia medica knowledge. Even though we are in the alleged glorious twentieth century, a drug does not spring full-armed from the brain of a medical Jove. In point of fact, I believe it would be an impossible task for any practitioner of experience to tell his reasons for the applications of drugs. If he desired to do so, he would find it impossible. He would not be able to analyze all the factors that entered into the mental elements that preceded the making of the prescription. He could not tell how much experience, how much previous training, how much the personal equation, the influence of a new or old idea, the suggestion of friends, had to do with the prescription of a particular drug in certain affections. I am a firm believer in the view that every man makes his own materia medica, and the material for that materia medica is often drawn from innumerable sources, some good and some bad, and we are continually revising and re-editing our own knowledge of a drug's power. I was once a symptomatic prescriber. What I am now I do not know. Possibly I am in a transition stage. Certain it is that I cannot view a case demanding drug treatment as I once did, and yet, with what some might term becoming and unblushing modesty, I announce that I am conceited enough to believe that I am as good—nay, a better—prescriber of drugs now than I

was, when only one way of applying remedies seemed the right way to kill the bird, disease, with therapeutic shot. All this latter conceit is predicated upon the results I once obtained, and those I obtain now; and, if my powers of discrimination are not at fault, I am a better physician for certain kinds of empiricism of which I am guilty—that is to say, if you will not admit the truth of a thought that sometimes strikes me very hard, namely, that the application of drugs is always empirical, even although we prescribe according to the law, or laws, or theories of action. We never know exactly what a drug is going to do. We must wait and see its action. Absolute, unequivocal response of patients to drugs with mathematical precision will alone remove the element from drug prescribing that justifies, and, indeed, in some cases enforces empiricism in prescribing. Pardon this little digression into the field of polemics, and let us talk about the iodide of arsenic.

I use the drug quite frequently in the treatment of pulmonary phthisis. If I have no definite symptoms to guide me in the choice of the iodide for this disease, what are the considerations that prompt me to its employment? you may legitimately ask. I do not know that I can explicitly define my reasons, but I will make the attempt. I believe that the arsenic itself, in small doses, is a stimulant to the processes by which good nutrition is maintained, acts as a tonic to the nervous system, acts upon epithelial cells, tends to correct blood dyscrasias, and acts as an alterative. Iodine stimulates the lymphatics, increases the appetite, acts directly upon the parenchyma, or, through the nervous supply, directly upon all glandular structures, is antiseptic, and, in small doses, tends to increase the subcutaneous fat (which, in large doses, it decidedly diminishes), and is possibly alterative. Briefly, I think that arsenic, as well as iodine, stimulates the upbuilding of nutrition. I think that arsenic acts well and favorably upon the epithelial cells especially, but also upon all the other tissues involved in the degenerative or inflammatory processes of phthisis; iodine stimulates the absorbents and the heart, and both, directly and indirectly, enhance nutrition, and possibly some of the drug may be, and doubtless is, eliminated by the blood passing through the lungs, acting there as a direct antiseptic to

the diseased areas. There may be other reasons or theories why this combination of iodine and arsenic appeals to my mind as an agent of service in the treatment of certain maladies, but I do not now recall them, and, as I intimated before, it is impossible to formulate all the considerations that move one to prescribe a drug and put them into cold words. You may ask me if I have no clinical picture in my mind for the administration of the iodide of arsenic in phthisis pulmonalis, and perhaps I can do better with a picture than I can with the reasons for the administration of the drug. Given a case of not very far advanced phthisis, with little associated bronchitis, with only moderate fever, slight or no night-sweats, only a small amount of expectoration, and I think highly of the combination, provided there exists no marked indications for the employment of another medicament. The arsenic thirst or nightly aggravation and the iodine bulimia may be present or not. You see, therefore, that my picture for the drug is rather a negative one; there is nothing prominent or characteristic about it. Just so I would have you understand the drug, for the iodide of arsenic is only one of many drugs that I have employed in the treatment of phthisis pulmonalis. I do not believe in the cut-and-dried treatment of any disease, and particularly so of any lung disorder, for I have never succeeded in curing any one case with only one drug. Besides, the drug treatment of consumption is often the least important factor in the therapeutic management of a given case. I have had, however, some cures from the iodide of arsenic, in connection with other measures.

When the iodide of arsenic helps this class of pulmonary cases, it seems to help them "all over," if I may use that expression. The sweats diminish, the expectoration becomes less, the appetite better, the appearance in general less worn, the anæmia less pronounced, the sense of well-being sometimes marked enough to be remarked, and also a gain in weight. This occurs very often in the poor dispensary patient who has no means to buy adjuvants, and still more frequently in those in walks of life where luxuries can be obtained. I do not give the iodide, then, to a patient simply because he has phthisis, but because of the underlying state of system that permits of the development of phthisis. It is the best all-round remedy

for the substratum of systemic soil that permits of the tubercular fruit growing, if you will permit this crude simile. Clinically, it is not well suited to those hasty cases with high temperature, profuse sweats, and rapid loss of flesh—to those patients, if you please, who seem to melt away before your eyes. Here you will have to employ more active measures, which are quite as likely to prove as unsuccessful in staying the progress of the malady as the combination of arsenic and iodine. In other words, the iodide of arsenic must have time to work, time to produce favorable nutritive changes, time to slightly alter the underlying soil, time to render the human house uninhabitable to the tubercular hosts. Sometimes the medicine, in these rapid cases, may be alternated with some more quickly acting drug, or some distinct palliative, with advantage.

The arsenic iodide is a favorite of mine in what I am pleased to term the senile heart. Given an old patient, with atheromatous arteries, a little swelling of the feet, a little shortness of breath, a little cough, and there are no indications for other remedies, that patient may be kept in the habit of living for a long period of time. In this condition it fairly rivals cactus, and that misnamed stimulant for the old, strychnine, which latter drug I confess to having a holy horror of in the treatment of the affections of the extremely aged, with their already too tense arteries, and obliterated and obliterating capillaries.

In bronchitis, with a dyspnoea disproportionate to the amount of inflammation, and many dry râles, but more moist ones, I also like the arsenic preparation.

In acute or subacute nasal catarrh, where the discharge is acrid and irritating, whether profuse or not, I also use the iodide of arsenic with benefit.

In stools that contain particles of undigested fat, I also give the iodide of arsenic preference over other remedies.

In enlarged lymphatic glands, while I have had fair results with the iodide of arsenic, I like the iodide of mercury, badiaaga and guaiacol better.

In poorly delayed resolution in croupous pneumonia, the arsenicum iodide is sometimes helpful, but it is not so good as sulphur.

In pleural effusion, after bryonia and sulphur, the iodide of arsenic is occasionally useful.

Finally, for poor anæmic children, who do not call for the calcareas, sulphur or the baryta compounds, I think of arsenic.

I am sorry that I cannot give you the symptomatic indications for the employment of this very valuable drug combination, but I leave that for those who are better versed in that sort of *materia medica*.

ILEUS.

BY S. G. A. BROWN, M.D., SHIPPENSBURG, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, at Pittsburg, September, 1901.)

STRICTLY speaking, ileus, or intestinal obstruction, is a surgical disease; but for one reason or another we are, at times, compelled to treat it on the expectant plan. The condition of the patient may be such that an operation would be extremely hazardous; or the family may object most emphatically to the use of the knife.

Intestinal obstruction is dependent upon a number of pathological conditions, the most frequent cause being strangulation. This is usually the result of recurring attacks of local peritonitis, the attending inflammation causing adhesions of one portion of the bowel to another; or loops of the bowel may be caught in some of the pouches or diverticula, etc. Of five cases of strangulation coming under my observation, four were males. Intussusception is an invagination of one portion of the bowel into a contiguous portion, resulting in a cylindrical tumor. It is usually found in children, the result of imperfect peristalsis. Volvulus (of which I have seen but one example) is a twisting of the bowel upon its axis, as a result of a long mesentery. The case here referred to was that of a single woman, 32 years old, the location of the twist being the sigmoid flexure. She had had recurrent attacks of what her physician designated "cramps," which, however, were evidently of the nature of a localized peritonitis. During her last attack, she dismissed her former attendant and called me in. I diagnosed the condition as one of volvulus, and, with the assistance of two old-school physicians, operated, and thereby

confirmed the diagnosis. From the manner in which the intestine was twisted, together with the weight of its contents, I doubt if expectant treatment could have corrected the trouble.

Enteroliths may produce temporary obstruction. One patient, a lady of 54 years, suffered excruciating pain for three days. When calling upon her the third day, she said she felt something give way in the abdomen, and the pain immediately ceased. At my next visit she informed me there was something extraordinary in her rectum, producing much uneasiness. With the aid of a rectal scoop I removed an enterolith, a perfect cube, an inch and a half in diameter, and as hard as a stone. Arndt says, "Enteroliths are formed by the deposit of phosphates of lime and magnesia around some foreign body." Following the removal of the enterolith, the old lady had a very large evacuation and made a speedy recovery.

Diagnosis as to the location of an intestinal obstruction is usually not difficult. Intussusception occurs nearly always in children. The onset is always sudden, vomiting commences early, and there is often tenesmus, with bloody evacuations. Strangulation also occurs suddenly, and is accompanied by excruciating pain; and, later, there is tympanites, singultus, vomiting of fecal matter, and absolute constipation. The distention may be but slight if the obstruction be in the small bowel.

The prognosis is always serious. Because of its tendency to a fatal issue, and because of the success I have had in the management of my last two cases, I have written this paper.

Treatment.—Endeavor as much as possible to maintain the patient's strength. Easily assimilated food, which results in but little residue, should be administered at regular intervals. Some authors recommend mild laxatives, but I believe they do more harm than good. Purgatives are undoubtedly contraindicated in an affection of this kind. Better use a high enema of warm olive oil, with patient in knee-chest position. The abdomen can be carefully kneaded at the time. Lavage of the stomach should *always* be persisted in, as it relieves the nausea, stimulates peristalsis, and possibly relieves distention. I have had no experience with electricity in this particular affection. Hot-water cloths sprinkled with turpentine and laid over the abdomen are very soothing.

Internal medication: *Nux vomica*, *colocynthis*, *arsenic*, or *terebinthina* may be given according to symptomatic indications. *Atropine*, however, has done more for me than any other remedy. It has been asserted that the adynamic form of ileus is due to a paralysis of the motor fibres of the splanchnic nerve, while the dynamic variety is due to an activity of the inhibitory nerve fibres. The underlying idea is to overcome the spasmodic condition of the intestinal musculature, and thus relieve the obstruction.

Atropine, as we know, acts as an irritant to the entire nervous system, producing a general hyperæsthesia of both motor and sensory nerve fibres. As a result, involuntary muscles become paralyzed and sphincters become relaxed. Among its symptoms are: Nausea; burning in stomach; colic, with painfully distended abdomen, sensitive to touch; violent cutting pressure in abdomen; pressing and urging in rectum; violent palpitation of the heart; cold limbs, hot head.

Of the two cases in which I prescribed *atropine* (both of whom recovered) I shall present but one, as the second is practically a repetition of the first. Mr. N., æt. 76, has been subject, for the last five years, to recurring attacks of severe abdominal pain. I never saw him in any of these attacks, usually sending him *nux vomica*, θ , which invariably gave relief; and, later, giving him a mild laxative to overcome the constipation, which I attributed to the action of the *nux*. On April 25th of this year he had another attack. I sent him *nux*, as usual, but the patient not getting any relief, I was called in on May 1st to see him. Why I was not called sooner, I do not know. Found him very weak; pulse 108, intermittent; temperature, 101° . He had passed neither stool nor flatus since April 25th. Inspection, percussion and palpation led me to believe I was dealing with a case of strangulation of the colon. I prescribed *colocynthis*, and gave a high enema of warm olive oil and saline solution, with no effect. Flannels wrung out in hot water and sprinkled with turpentine were placed on his abdomen. Matters kept growing worse, however; he began vomiting, first watery, later, stercoraceous matter. The abdomen became frightfully distended, and singultus made its appearance. He suffered great pain, had dyspnœa and intense thirst. On May 5th I washed out the stomach to relieve the nausea. Gave a

hypodermatic injection of atropine sulphate, $\frac{1}{50}$ gr., and left four powders of the same drug, each containing $\frac{1}{75}$ gr., directing that a powder be given every four hours until the bowels were moved. Upon my arrival the next morning I found the patient resting quietly, having had a large evacuation, accompanied by an enormous amount of flatus. The singultus and vomiting had ceased, and the distended abdomen was considerably reduced in size. The patient continued to improve, and made an uneventful recovery. This patient took nearly $\frac{1}{13}$ gr. of atropine sulphate in sixteen hours, yet no deleterious results were exhibited.

I am aware that two swallows do not make a summer, but when such men as Drs. Batsch, Seber, Festner, Schulmann and Ostermaier have recorded similar experiences, I am led to believe that we may entertain some hopes, at least, of having in our possession a remedy that will rob obstruction of the bowels of many of its terrors and save ourselves many moments of anxiety. I would here remark, however, that it is necessary to diagnose the case correctly, as I believe that, should we prescribe atropine in a case of volvulus with adhesions, we would probably kill our patient.

ACETATE OF COPPER AS AN OXYTIC.

BY GEORGE F. LAIDLAW, M.D., NEW YORK.

(Read before the Homœopathic Medical Society of the State of New York, Sept., 1901.)

ACETATE of copper in doses of one-quarter to one-half grain is of real service in hastening the progress of tedious labor. Tedious labor is a condition, not a theory. It occupies a place in every text-book on obstetrics, under the head of delayed labor, prolonged, protracted, tedious or powerless labor, uterine feebleness, inertia, atony or paralysis. Tedious labor has no precise time limit. In a process like labor, the normal duration of which is from half an hour to a week, it is difficult to state in precise terms just what constitutes the condition. The physical state of the patient, the character of the pains, and the progress or lack of progress they make, are factors

equally important with time in determining the extent of tedious labor or uterine inertia which demands the interference of the physician, for tedious labor is a condition in which the physician should always interfere. Sir James Simpson "proved conclusively that both the maternal and the fetal mortality were greatly increased in proportion to the entire length of labor."*

Leaving out of consideration anatomical interferences to delivery, as deformed pelves, monsters, and locked twins, which are among the rarer phenomena of obstetric practice, I confine my remarks on the acetate of copper to the more frequently occurring cases where the difficulty is physiological, and, with the soft parts, insufficient contractions or rigid os; or that debatable condition, spasm of the internal os; or rigid perineum, the frequent occurrence of which I am also inclined to doubt; for, in the few cases of apparently rigid perineum that have fallen to my lot, I have always been able to make out a firmly constricting cervix about the foetal head.

The interference with protracted labor that is justified and necessary is laid down in all the text-books. I will not go over the ground of opium, chloral, quinine, ergot, mechanical dilatation, compression and forceps. I will presume that the physician will bear in mind the necessity of evacuating the bladder and rectum. I will simply add to these well-known resources in tedious labor the use of acetate of copper.

The first patient to whom I gave acetate of copper as an oxytocic had been in labor sixteen hours, and had delayed ten days over the expected time of delivery. At the sixth and eighth hours she received thirty drops of fluid extract of ergot and ten grains of quinine, with the result of obtaining stronger pains, but no progress of the head, which was a normal presentation and firmly held by the cervix at a dilatation of three inches. The waters had come away early. At the end of fourteen hours the pains died away, and for four hours there was no further effort. I had read in Rademacher that copper was anciently in high reputation for stimulating the pains of labor, and concluded to give it a trial, as the good condition of the patient justified temporizing with drugs and did not seem to

* W. S. Playfair, *Science and Practice of Midwifery*, 1898.

demand instrumental interference. I administered ten drops of Rademacher's tincture of copper,* and mixed sixty drops in four ounces of water, of which a teaspoonful was given every fifteen minutes. Within two hours the pains reappeared vigorously, the head progressed rapidly, and delivery was accomplished in three hours from the first dose of copper. The placenta was delivered easily in half an hour, a moderate perineal laceration was repaired, and the patient made a good recovery.

In this case you may think, as I did, that the action of the copper might have been confused with that of the preceding ergot, or that the ergot caused cervical spasm, and that this spasm either relaxed spontaneously or was dispersed by the copper; or, again, that it was only natural, after a period of quiescence, for the pains to return with vigor and complete the delivery. In this case the quinine had little influence. The expulsive action of the ergot had ceased, and our judgment must decide between the copper and natural recovery of power. As the acetate of copper is a perfectly safe drug in these doses, I concluded to test the matter further, and next gave it to a primipara who had struggled with ineffective pains of the first stage for ten hours. Quinine in two ten-grain doses increased the pains, but brought no real progress. I gave ten drops of the tincture of copper every fifteen minutes for four doses. In one hour vigorous pains appeared, the waters came away, and delivery was accomplished in two hours and a half from the first dose of copper.

Next I gave it to a multipara in her fourth confinement, after six hours of dry labor with delayed cervical dilatation. In this case I have no record of the dosage given, but I remember distinctly the promptness of the appearance of effective pains and their satisfactory conclusion.

I recently attended a mother in her second confinement. Her first child had been born five years before, and had required a labor of fourteen hours. With the second child, the pains came on at ten o'clock in the morning, but did not become severe and effective until four in the afternoon, when I was summoned. The cervix had attained a dilatation of less than two inches and the bag of waters was unbroken. Re-

* A solution of 7 grains acetate of copper to one ounce of alcohol and water.

turning in two hours, and finding that, in spite of vigorous pain, the cervix remained about the same size, I gave her thirty drops of tincture of copper, and left two other doses to be given at intervals of half an hour. Returning at the end of another hour, I had the satisfaction of finding the cervix already four inches in diameter; and by a succession of vigorous pains, with short intermissions, the child was born in two hours and a half from the first dose of copper.

Another more striking instance of the action of copper during labor occurred in a primipara in whom labor commenced on the two hundred and eightieth day with vigor pains, which continued for five hours and then died away. Slight, ineffective pains came at intervals of thirty minutes for several hours. Within thirty minutes of the first administration of thirty drops of copper tincture the vigorous pains reappeared, and dilatation and expulsion were complete in one hour from this time.

In another case, after eight hours' fruitless effort, with dilatation of the cervix advanced to a diameter of only three inches, and the bag of waters unbroken, a thirty-drop dose of the copper tincture, repeated three times at intervals of twenty minutes, brought on the usual vigorous, expulsive pains, and delivery was completed in about two hours.

This comprises my experience with acetate of copper as an oxytocic, and covers a space of three years. I am not partial to forceps, and believe that, in spite of the most careful handling, the danger of injuring the child is great, and perhaps this has led me to delay longer than is the habit of some physicians for the development of the natural expulsive forces, or their stimulation by drugs. I am satisfied that it is possible to so stimulate the pains, and that the most reliable drugs are quinine and acetate of copper. In Guernsey's and in Sheldon Leavitt's books on obstetrics there are given the indications for many drugs in uterine inertia. I have tried them faithfully in my daily practice, and was so uniformly disappointed that I do not now look for a similitum. Quinine and copper seem indicated in different cases, but it is only by trial that their applicability can be determined. I believe them to be harmless and without the risk of ergot. I have used ergot to some extent during labor, and while I have not observed the uterine

spasm, with attendant evils, that is commonly attributed to its use, still I would rather replace it by a drug of less sinister reputation.

The acetate of copper is harmless in the dosage given. I have used it about five years in many diseased conditions from infancy to old age. Its only unpleasant feature is its nauseating action; but this is only observed in certain sensitive cases, and can be controlled by giving the dose in milk, in coffee or lemonade. I have carefully examined the urine of patients while taking the remedy, and have seen no bad effects. Copper does not produce the tonic uterine contraction that is attributed to ergot, but frequent, powerful expulsive pains, with distinct intermissions. Under its action the rigid cervix relaxes, whether due to the power of the pains or to a specific relaxing effect of the copper. I think that it is the force of the contractions of the fundus. In copper cases, I have not seen any more damage to the perinæum than in undrugged labors. There is no tendency to retention of the placenta. In fact, the placenta often seems to be expelled into the vagina with the last pain that brings the baby. There is absolutely no tendency to post-partum hæmorrhage after the use of copper, and the lochial discharge is apt to be scanty and of short duration. Copper can be used in any stage of labor; and, while I would use smaller doses in albuminuric cases, I have never seen any unfavorable urinary symptoms from its use. As already stated, copper will not correct a deformed pelvis, or deliver monsters, or empty the bowels or bladder; but in ordinary cases of tedious labor from uterine inertia or rigid cervix the drug has done effective work, and it has done it, according to the long-established principles of our art, quickly, safely and pleasantly.

ABROTANUM IN MARASMUS OF CHILDREN.—This remedy, Abrotanum, is very useful in the marasmus of children when there is a gnawing hunger and ravenous appetite; where the child continually cries for something to eat, and in spite of the great amount consumed, it continues to emaciate. The abdomen is greatly distended, with hard lumps in different parts. Food passes undigested, with alternate constipation and diarrhœa. The skin is flabby and hangs loosely.—Dr. Louis E. Bunte, *Hom. Jour. of Obstetrics*, September.

OBSTETRICAL OBSERVATIONS.

BY E. P. SWIFT, M.D., NEW YORK.

(Read before the New York County Homœopathic Medical Society.)

IN obstetrical work, as in all other departments of clinical medicine, the best results are secured by the physician who does not permit himself to be governed by any stereotyped method in the management of his cases, but who makes a study of each by itself, and varies his treatment to meet the varying conditions as they arise. He does not lose sight of the fact that the processes of gestation and parturition are physiological and not pathological, that to deliver the woman is Nature's prerogative, and that the right of the physician to interfere is based solely upon the recognition of an abnormal condition which it is within his power to correct. Quick to detect such a condition, he does not fail to assist Nature by removing all possible obstacles from her way, by rendering timely and effective aid when her efforts are unavailing, and by repairing damage which she may have been powerless to avert.

As defined many years ago by one skilled in the art, it still remains the duty of the accoucheur "to place a living child in the arms of a living mother;" and we may add, in the light of our modern knowledge of the sources of puerperal infection, a mother with a clean uterus and genital canal.

The following brief review of experience is based upon about 500 consecutive cases of labor occurring in private practice, during a period of eighteen years.

Of the more serious complications of labor but three cases of eclampsia, one of lateral and one of central placenta prævia, have occurred; and in none except the last mentioned was there sufficient hæmorrhage to endanger the mother's life or prolong her convalescence. There were no cases requiring craniotomy or Cæsarian section.

The eclampsia cases were all primiparæ, the convulsions occurring in two within three hours after delivery at term, and in one accompanying premature labor at the seventh month. Of those occurring postpartum, one followed the birth of

twins and was extremely severe, the convulsions occurring every 15 or 20 minutes for three hours, then subsiding, but re-appearing after four hours, upon suspension of remedies. Resuming the treatment, the convulsions again ceased and did not return. The urine in this case contained but a trace of albumin prior to confinement, but was deficient in solids. She has since borne two children without accident. In the other post-partum case there were but two convulsions, the first occurring an hour after delivery without premonitory symptoms, except slight headache.

The third case, in which the convulsions occurred during the first stage of labor, was most severe. Dilatation of the os and instrumental delivery were accomplished as rapidly as possible, and were followed by a considerable hæmorrhage. The convulsions continued, however, for about two hours, and were followed by coma. Several hours after cessation of the convulsions consciousness gradually returned and recovery ensued.

Judicious treatment will in most instances prevent the occurrence of eclampsia; and, other means failing to control the uræmic symptoms, the induction of premature labor is not only justifiable, but of supreme importance. Whoever has had the experience of attempting to effect delivery during the paroxysms of an attack of eclampsia will thereafter spare no effort to avert such a catastrophe. Whatever theory may be accepted as to the cause of the toxæmia of pregnancy, I am convinced that a marked diminution in the amount of urea excreted is of vastly more importance, as a danger signal, than the presence of either albumin or casts. It is a matter of common experience that convulsions may occur when neither of the latter have been present in the urine, but never when the relative proportion of solids has been near the normal average.

During the paroxysms of eclampsia, tincture of *veratrum viride* and chloral hydrate have, in my experience, proved the most effective remedies. Inhalations of chloroform are of less value, though possibly they modify somewhat the severity of the muscular contractions. Large rectal injections of saline solution are useful.

In one case of placenta prævia the hæmorrhage was controlled by tampon until dilatation was sufficient to permit the introduction of the hand and rapid delivery of the child by ver.

sion. A small portion of the placenta remained adherent until the tampon was removed. Both mother and child lived. In the other case one edge only of the placenta occupied the os, and hæmorrhage was held in check by tampon until stopped by the pressure of the advancing head.

My experience has probably been unique in that I have never had a case of retained placenta; *i.e.*, one in which, except on account of hæmorrhage, it was necessary to introduce the hand into the uterine cavity to effect its separation. I have come to believe that cases in which the placenta is so firmly adherent to the uterine wall as to require this treatment are extremely rare. It is a condition which exists oftener in the mind of the attendant than in the interior of the womb.

The uterus in most instances takes advantage of the period immediately following the strong contractions which have resulted in the expulsion of the child for a more or less prolonged rest, the pains, which may have been occurring every minute or two, ceasing entirely, and the organ remaining quietly contracted upon the placenta, effectually controlling hæmorrhage. From fifteen to thirty minutes, or even a longer period, may elapse before sufficient relaxation takes place to allow the placental mass to engage in the os, and assume a position from which it will be easily expelled by the next uterine contraction. Too often the impatient novice, after waiting but a short time, remembering all he has heard and read about adherent placenta, informs the woman that her afterbirth has "grown fast," administers an anæsthetic, and proceeds to "peel it off." A little more patience, with careful pressure over the fundus, accompanied, if necessary, by gentle traction on the cord, would have accomplished the delivery of the secundines in a natural manner, and with greater safety to the mother. As Ayers has well said, in his recent work on "*Obstetrical Diagnosis*," "Adherent placenta occurs much more frequently in the first cases of obstetricians than after they have extended their experience."

The Fabian policy of conquering by waiting is that which secures the best results in the management of the third stage. An exception to this rule is found, however, in the hæmorrhagic cases, which of course permit of no delay in removing the uterine contents.

A somewhat unusual and startling experience was the occurrence of labor upon the second day of an attack of acute erysipelas. High fever, with delirium, continued during three or four days, and the lochial discharge became somewhat offensive; but general infection did not occur, and the patient recovered.

The only maternal death in this series took place in the early days of antiseptic midwifery, and was due to puerperal fever.

Second only to the beneficent results which, in the domain of surgery, have followed the discoveries of Pasteur and Lister, are the triumphs in the field of obstetrics which have been achieved since the rôle of the microbe in the production of post-partum disturbances has been understood and its entrance guarded against. But it is unfortunately true that the gospel of cleanliness needs still to be preached, and the fact of its necessity impressed upon physicians and nurses and midwives, until the physiological act of parturition shall be effectually safeguarded among all classes of people, and as free from danger to maternal life as the Creator intended it should be.

TUBERCULAR ADENITIS.

BY HERBERT P. LEOPOLD, A.B., M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of Pennsylvania, Pittsburg, Sept., 1901.)

It is not the purpose of this paper to recite any new theory or departure on this subject. To have given a brief *résumé* of the causes, diagnosis, and particularly of the treatment which has given us the best results, I will be content, if, by your discussion, something shall be learned in the way of shortening the course of this dreaded "tubercle."

These conditions are treated too lightly by the general practitioner, or else not recognized in time to prevent a tedious and prolonged after-treatment.

For a long time the word "tuberculosis" has suggested to the medical mind a tolerably well-defined idea. It is true that pathologists have variously applied this term, but to the clin-

ician it has meant a disease in which the most prominent feature is the development, in various parts of the body, of microscopic nodular masses which have a tendency to multiply with more or less rapidity, and to take on a degenerative process, in which the tissues occupied are destroyed, and often the life of the patient imperilled or lost.

The term "scrofula" is more restricted in its application today than formerly; the history of this subject shows that its domain has been encroached upon for generations, until now it occupies but a small part of its once extensive territory. To illustrate this contraction, it is only necessary to mention that at one time it claimed as its own, cancer, hereditary syphilis, rickets, etc. The tendency to curtailment is still manifest, and the term is now far less common than it was twenty-five years ago. The most comprehensive definition is that given by Treves, when he declares it to be "a tendency in the individual to inflammation of a peculiar type"—in other words, a "diathesis."

As to the etiological factors, we find tubercular infections of the glands to be most prevalent in childhood, between three and ten years of age, but it is not uncommon to find this condition in adolescence, particularly in hospital practice. The colored race is the most prone to this infection, and particularly those who are forced to live continuously in the impure atmosphere of badly ventilated lodgings. In addition to the infection with the tubercle-bacillus, local causes are usually present, as adenoid growths, chronic pharyngitis, enlarged tonsils, chronic otitis media, conjunctivitis, and pathological conditions of the skin and mouth. For the production of the disease, therefore, it appears to be necessary to have, first, favorable local conditions; and, secondly, exposure to infection. There is an old German axiom, "*Jedermann hat am ende ein bischen tuberculose*," a statement partly borne out by statistics showing the proportion of cases in persons dying of all diseases. As a rule, the sub-maxillary glands are the first to be involved; subsequently the post-cervical, supra-clavicular and axillary may follow suit, and the disease may extend downward to the bronchial glands. Less frequently we find the disease manifest in the inguinal region. Both sides are usually affected, perhaps one to a greater degree than the other. The affected glands slowly enlarge from the size of a bean to, sometimes, that of a

hen's egg. They are smooth, firm, and at first separate; later the several tumors coalesce, and form rounded but irregular masses. The overlying skin is freely movable, unless one or more glands suppurate, when it becomes adherent, and the abscess (unless operated) points and discharges, leaving a sinus, which heals slowly. When the glands are large and growing rapidly, or when suppuration is in progress, there is fever, anæmia, and loss of flesh.

The diagnosis should be based upon the presence of slowly enlarging glands in a child (probably tubercular), with the co-existence of nose and throat disease, or other pathological condition about the head. Aside from the symptoms and physical signs, with a coincident tuberculosis of other organs, the diagnosis depends upon the presence of the tubercle bacillus in the pus or scrapings from these lesions, or upon the results of inoculation of these substances into guinea pigs, but principally by the disposition to show caseation, softening and abscess formation. The contents of these abscesses contain small particles of *débris*, with an appearance not unlike cheese.

In no case, we think, does tuberculosis of the external lymph glands cause death, though the course is often protracted, extending, in some cases, for six or eight years. However, with proper treatment ultimate recovery may be confidently predicted in the great majority of cases.

The treatment must be varied according to the needs of each individual case. The one part—and often the most important—of a surgeon's duty to a patient is to combat the tendency of the general system to yield to the incursions of the bacillus. If this task be left undone or underdone, his efforts in other directions will probably prove unavailing. Local applications are of no value, and most of them are positively harmful (as the linseed poultice of our grandmothers, which fulfilled three conditions: heat, moisture and *filth*), are relics of the past, and should find no place in the modern treatment of disease. It is important in every case to remove from the nose and throat all sources of local irritation, and any other pathological condition about the head should receive attention, if for no other reason than to prevent constant glandular irritation, which produces favorable conditions for the activity of the bacillus. Constitutional measures include sunlight, fresh

air, good food, medicines as indicated, and pepto-mangan (Gude). The operative measures are indicated if, after a reasonable course of constitutional treatment, the glands continue to increase in size and number. If, however, suppuration should take place, they should be opened at once, to prevent the extensive undermining of the skin. For this, we have found the method of Hilton all that could be desired. It consists in making a small opening into the skin, and then burrowing into the cellular tissue with a pair of hæmostatic forceps (being blunt, they can do no harm); if the opening is to be enlarged, the blades may be opened, held rigid, and withdrawn. The cavity should then be washed out with an antiseptic solution (we have long since discontinued the use of peroxide of hydrogen) and packed. In some cases it is best to curette the capsule, and even cauterize it. But in all cases, rough handling and squeezing of the gland or surrounding tissue should be avoided. Experience has taught us that the best results, in operating, are obtained by avoiding violent tearing out of the glands, injuring as little as possible the tissues, being careful not to rupture the capsule and allow the tuberculous material to escape into the healthy tissue. Prolonged dissections are to be avoided, and in removing deeply-seated glands there is great danger of injuring the vessels and nerves or the dome of the pleura. The devious and unforeseen relations that sometimes exist invest their removal with a sense of responsibility that often begets a strong feeling of uncertainty as to the wisdom of the attempt, in many instances. Apparently simple cases often become, as the operation progresses, difficult and complex, sometimes even dangerous of execution. Even though a divided vein be ligated, embolism following detachment of a thrombus is a danger which must not be overlooked. The incisions for the removal of these glands vary in accordance with the situation and extent of the glandular involvement. The S-shaped incision of Hartley, employed as a whole or in part, as circumstances require, has proven very satisfactory at our hands. In all cases the incision should be free enough to allow of ample working room. Safety of execution should not be exchanged for cosmetic results. A good light, plenty of time and aseptic detail should be at the command of the operator. When possible, chloroform should be given, to

avoid the congestion of the vessels. Some of the advantages of an operation over leaving the case to Nature are:

1. Frequently the glands are more easily removed before periadenitis develops.
2. It leaves a clean scar, instead of a large, irregular one.
3. It shortens the disease, and prevents the long and tedious suppuration.
4. It is a radical measure.
5. It avoids the danger of general infection by removing the tuberculous focus.

DIAGNOSIS IS A PREREQUISITE TO TREATMENT.

BY FRANK H. PRITCHARD, M.D., MONROEVILLE, OHIO.

IN the September number of this journal Dr. J. P. Sutherland, though admitting the vastly prepondering evidence to the contrary, has examined the arguments of those who look upon a diagnosis, or an attempt at one, as a waste of time, a horrible possibility to be faced or a feeling that something depressing both to patient and physician might be unearthed. I must say that it has been my experience that, whether looked for or not, if a dreaded disease is preying on one's patient, the sooner the physician finds it out, the better it is for both. Things have to be faced, and there is no use in running away from them nor dodging them until the patient and his friends are able to make the diagnosis themselves. Not to attempt to make a diagnosis in every case is a mistake, an abuse of the patient, and an incentive to slovenly work. It leads to faulty observation and conclusions; it does not broaden one's knowledge of disease, nor add anything of value to that already known. How often a seemingly simple thing is the beginning of a serious illness, which, if not foreseen and forewarned against, lands both patient and physician in a distressing condition of affairs which is both humiliating and destructive of confidence in one's medical adviser. As Dr. Sutherland admits, there is something in medicine more than mere medicinal treatment, more than dosing. There is a world of things to consider. If a physician does not stand on the firm ground of a carefully thought out

diagnosis he feels ill at ease, he cannot speak intelligently of the case either to the patient or his friends. How can he predict complications or the termination if he does not know what he has in hand? If a complication arise he is all at sea, he hesitates, calls it another disease, shakes the patient's confidence and prepares the way for trouble for himself, and possibly loses valuable time which should have been used in treatment. No man ever asserted that a diagnosis was always possible. We are all fallible. Medicine is comparatively a new science; for if one except Greek medicine and the progress that has been made during the past few centuries, but little has been recorded of value. The Arabs did something to advance chemistry and pharmacology, but in actual medicine they did but little. What the future holds for us is greater than what we now know.

A diagnosis, if possible, is the key to the whole situation in a case. It enables one to prognosticate, to treat intelligently in a broad sense. Mere symptom-covering, *symptom-deckerei*, is only a very small part of treatment, and a very unsatisfactory part at that. Etiological therapy is far more satisfactory. If a patient comes to us with an intercostal neuralgia, it will not do to be content with determining that alone. It may be that the unfortunate seeker for relief is the bearer of an aortic aneurism, as I recently noted in a case. The patient had been treated for "heart disease," and because he had a mitral murmur, presumably from dilatation, he had been given digitalis, etc. An examination of his chest revealed a throbbing area to the right of the sternum, in the third intercostal space, which presented a decided throbbing and heaving with a thrill. Such a case might easily lose valuable time by improper treatment. Homœopathy offers nothing of actual service in such cases that I know of. But the treatment by the iodides does, for a much better prognosis of late years is given such cases by their administration. Prof. Gairdner's masterly articles in Albutt's "System of Medicine" will serve to enlighten one. How unsatisfactory would symptomatic treatment be in such a case. How useful and comforting would certain knowledge be in such a case. It is not necessary to make a diagnosis, and then panic-stricken, in a serious disease, to drop everything and doom the patient to instant or lingering death, as the case may

be. Much may be done in all serious conditions to prevent further progress, to arrest disease, and to save what is left of noble organs. But to learn all that one can of the "natural history of disease," to quote Trousseau, is our aim. One cannot restore a patient with tuberculosis of the lungs or Bright's disease to his former state of health, though often, by persistent effort and intelligently directed means, one may accomplish wonders. But, to learn to know the beginnings of these great diseases, these *grandes maladies et infections*, one must get into the habit of having one's eyes open, always to strive to make a diagnosis, to understand the pathological condition that we have in hand. Then one gradually will get to know disease as one meets it, and be able to prevent it. The feel of a patient's pulse, the high tension of the radial artery, will bring up before one interstitial nephritis, with its consequent affections,—as apoplexy, uræmia, miliary aneurysms, aortic aneurysm itself, and all the manifold dependent diseases. To learn to recognize the place in pathology that granular kidney has in medicine, one should read Dr. Samuel West's masterful work on "Granular Kidney." These diseases do not come to us labeled; we are obliged to seek for them; and unless one get into the habit of first and foremost attempting to make a carefully reasoned out diagnosis, one will miss many of them, and the golden opportunity for help slips by us.

To find albumin in a patient's urine is not to diagnose Bright's disease, as some assume, though albuminuria, if persistent, breeds no contempt by familiarity. Bright's disease is not the incurable disease it once was thought to be. A physician need not feel a cloud of gloom settle over him if he detects it, for much may still be done if taken early. Faulty habits may be corrected, proper climatic, hygienic and medicinal measures taken that may do much in certain forms. It is only by careful diagnosing that one learns to distinguish when and where one may bring help and hope to a patient.

Take, for example, a case of tertiary syphilitic disease of the brain in a young man who has had the disease several years before; his memory failing, his health being undermined, his face twitching, parietic symptoms appearing. Unless one intervene energetically that patient is doomed. I saw such a case some time ago. Symptomatic prescribing would not help him;

the iodides and mercury did, and restored him to health. Here only the right diagnosis and etiological treatment, to use Huchard's expression, saved him.

There are no sadder cases than those due to hereditary syphilis, for it strikes the young and innocent, blasting their hopes of health and life. Of what use is life to one with a perforated palate, with a disfiguring syphilitic ulcer or a hereditary syphilitic keratitis, if his malady be allowed to go unrecognized? If one read Dr. Donner's excellent work on "Late Hereditary Syphilis," and peruse the tales of the hopeless and discouraging conditions into which such cases may develop if their affliction be not diagnosed by one who sees through a maze of conflicting symptoms and traces them to their proper source, one sees, above all, the need of an early diagnosis. Of all things here, a diagnosis is needed before treatment.

Take, for instance, the case of a little child, weak and spindling, who has passed through an attack of measles, influenza or whooping-cough, or who develops, apparently without cause, a state which is seemingly "malarial," with daily chills, high fever, drenching night-sweats and rapid emaciation. Such little fellows seem to lose several pounds a week, or even daily, for the flesh appears to melt right off their weak bodies. The chances are that such a patient has broncho-pneumonic phthisis. If one listen to the lungs, great areas, possibly of a lower lobe, will be found full of fine râles, with dulness on percussion. There are loose, racking coughs, with raising of much mucopurulent sputa, a heavily coated tongue and pleuritic pains. To prescribe for these little patients without understanding the natural history of their condition is far from pleasant, as I have found. Here, again, etiological treatment will soon, in a number of cases, do a great amount of good. I have had such cases on my hands, and searched the *matéria medica*, but I cannot say that I have been encouraged by the results. To feel the ground firmly under one's feet here surely requires a diagnosis. How "mean" one feels if one has a case and cannot make its nature out. How pleasant it is for patient's friends and relatives to ask for information when you are all at sea yourself? We have all been right there, and know. If one be a good dodger and an able mystifier he may succeed for a time, but the people after awhile find such a one out.

One cannot always make the right diagnosis, nor even, in certain cases, get within a stone's throw of it; yet I maintain that it is our duty always to attempt it; to have a routine method of looking one's patients over, so that but little will escape one. It is not necessary to tell the patient all that one knows nor to get panic-stricken at the name "Bright's disease," "consumption," etc., for familiarity with disease will inform us that patients more often recover from incipient stages of both if we look for these beginnings instead of waiting until they are forced upon us in later stages, incurable. Pathology may, in the estimation of some, be a greatly over-estimated science, and there are those who become pessimistic—so much so as to feel themselves unequal to the task of finding resources with which to fight disease, if they know the whole truth; yet I maintain that it is chiefly those who are content with mere surface readings, who do not try to meet diseases more than half-way, who are unwilling to delve below the surface and to become intimately acquainted with their beginnings. If we are not willing to face these things squarely, there certainly will come a day when they will thrust themselves before us and cause us humiliation and disgrace. It is readily admitted that many cases there are which cannot be diagnosed; they have not developed sufficiently to be recognized; they appear under such strange masks that we do not know them; the patient may be stupid, may deceive, etc. Very few of us can recognize a hæmorrhagic pancreatitis, for we should probably hold it to be one of intestinal obstruction, yet we might try to keep it in mind.

A tubercular meningitis developing in an unusual manner, of all things, to my mind, requires a correct diagnosis, for there are but few remedies indicated, and these, to be of service, must be given early and persistently. How useless is it to waste time with belladonna, bryonia and hellebore when iodoform, possibly lycopodium and calcarea, may do something for this notoriously fatal disease? I flatter myself that I have saved one case by an early diagnosis; but I also know of cases that have gone on to death. They were treated as typhoid fever. Whether the right diagnosis, made early, might have saved them is naturally very questionable. How much blame would fall to a physician for having lost a simple case of

typhoid fever, which really was one of tubercular meningitis, when the proper diagnosis would have enabled him to predict the outcome? It might have been disheartening to parents and physician, yet the disease would go on without considering any of them. A graver diagnosis than the facts warrant is only made from incomplete knowledge or by waiting in cases until the diagnosis is forced unwillingly on one, rather than meeting the disease half way. No careful physician will thoughtlessly and without due warrant tell the worst, even if he fears it, until he is fully satisfied that the worst is inevitably to be feared. One may state modifiedly, qualifiedly, what may intervene if our measures fail. It is only from half-knowledge, from being satisfied with prescribing for a "headache" as a headache, not as a manifestation of kidney, uterine, eye disease, etc., that one lets cases slip on and on until they round up with a something suddenly and humiliatingly different from what they on the surface seemed to be, that one gets into trouble. For instance, a few weeks ago I was called to a man of fifty, slight in build, pale of complexion, who had been in poorer health than usual for several months. He then had a gastro-intestinal catarrh, such as many have during the summer months, but his diarrhoea was *painless*, and he vomited quite a little. He picked up slowly, and could not eat, for he would vomit if he attempted to take his ordinary food. His pulse was weak, he was prostrated, his urine thick and dark-colored, full of urates, of a high specific gravity. Different remedies given for the vomiting alone had no effect. But when his urine was found quite albuminous, with flocculi of the non-retractile variety, it was plain that he had a congested kidney, probably granulating, which had become incapable of doing its work. Placed on a milk diet, in a few days the quantity of urine began to increase, and in two weeks he was able to be about again. He is not well, but, having a clear understanding of the care necessary in his diet and clothing, and in general of so regulating his life as to ward off strain from his kidneys, he is better able to take care of himself and I am better able to appreciate his future illnesses. He has not been told that he has Bright's disease, but still he has a granular, or, better said, a granulating kidney, which will ultimately kill him; but the end may be years off yet, and treatment may do much for him yet.

Da Costa, in speaking of those cases where treatment becomes the touchstone of diagnosis, asks himself the question, Does this demonstrate that the diagnosis of a case is not necessary for its treatment? "Not at all. It simply proves that we are sometimes obliged to aim at removing symptoms without understanding their source. But it does not prove that if we understood their source we should not be better able to remove the symptoms. The physician who undertakes to relieve disease simply by attempting to allay its symptoms, regardless of the cause, and without understanding their true relation and significance, is groping in the dark. His treatment is vacillating; drug replaces drug; alleviation is taken for a cure; and the experience gained is utterly untrustworthy. One great advantage, indeed, of attending carefully to diagnosis, is that it enables us to use remedies knowingly and with decision; to appreciate what they are affecting; to abstain from such as must be injurious. There is less needless meddling, more calmness; the treatment rises above the consideration of the moment, and takes into account what is for the patient's ultimate good. It is sometimes urged that the accurate detection of disease makes timid practitioners, and deprives them of confidence in medicine. More just is it to say that it shows how wide is the chasm between our acquaintance with morbid conditions and our acquaintance with remedies; how far, unfortunately, our skill to detect disease outruns our power to cure it."

METHYL ALCOHOL BLINDNESS.—Among the toxic substances having a selective affinity for the visual apparatus, methyl alcohol is now beyond a doubt deserving of decided recognition, not only from a toxicological standpoint, but from one of prophylaxis.

The case of blindness from drinking methyl alcohol, that had been taken under the supposition of its being cologne spirits, as reported by Dr. Harold Gifford, of Omaha, in the *Ophthalmic Record*, July, 1901, is an indication that all packages containing methyl alcohol should be marked "Poison." The subject, while it is no longer a novelty in ophthalmic literature, sounds a warning note to the medical profession that in all cases of sudden blindness of obscure origin this substance should be thought of. It is not uncommon for those addicted to alcohol beverages to procure the "next best thing," when in a locality that supplies no alcoholic drinks, and the danger to sight and even life requires that precautionary measures be observed.—*Phila. Med. Journal*.

EDITORIAL.

THE ATTITUDE OF THE PHYSICIAN TOWARDS THE REGULATIONS
OF THE BOARD OF HEALTH.

THE imminent danger of an epidemic of small-pox in so many localities at the present time renders of peculiar interest and importance a consideration of the various means for its prevention, and the attitude of the individual physician in regard to them. Anyone who has had practical—we will not say personal—knowledge of this loathsome disease will eagerly adopt and willingly assist in enforcing any regulations which have shown themselves of use in limiting its spread.

The absurd remark often heard from anti-vaccinationists that they would rather have small-pox than expose themselves to the fancied risks of being vaccinated is founded upon an ignorance so dense as to be pitiable, if it were not so exasperating and so dangerous in its effects on others.

The tables of statistics, compiled from different points of view as to the results of vaccination, all tend to show that, while it does not confer absolute immunity, it is the most effectual means known to the profession of lessening the susceptibility to the disease, or of favorably modifying it when it occurs. The opportunity for gathering reliable statistics in regard to the virtues of vaccination have been exceptionally favorable, since it has been applied at the same time to so many individuals under the same conditions and circumstances, as in armies, prisons, among school children, etc. The attempt to substitute other measures as of equal value and less offensive is unwarranted in the face of a threatening epidemic. Statistics of all such measures are exceedingly meagre, and, when carefully examined, very unreliable. We well recall how, during the epidemic in '71, a certain remedy for the disease, again being brought forward as superior to all others as prophylactic and curative, was credited with the prevention of a case of threatened variola each time that a backache of any

kind or from any cause, even without other symptoms, disappeared while it was being administered at long intervals.

Again, as a minor consideration, we would personally prefer not swallowing a virus which is so disgusting and dangerous when inserted into the arm.

Unfortunately, the occurrence of a number of cases of tetanus following after vaccination has given unmerited support to the contentions of the anti-vaccinationists. The results of a more careful and exhaustive examination into these cases have shown that they were in no way dependent upon the vaccinations except in so far as they offered an opportunity for infection by the tetanus germs, due to filth and want of care.

That the reaction, in cases even of the most carefully carried-out vaccination, should in some instances be excessive is not to be wondered at, considering the many individual idiosyncrasies met with in practice generally; and, in view of the great numbers subjected to this operation, and of the circumstances of haste and consequent carelessness so often attending it, it is surprising that the number of misadventures is so small.

The theory upon which the practice of vaccination is based is one which is receiving a constantly widening application, and, according to many, is looked forward to as the most promising method of treatment in the future.

Both theoretically and practically, therefore, vaccination recommends itself to the physician as a measure to receive his earnest support.

The next question presenting itself is that of compulsory vaccination of children attending schools, at first applying only to the public schools, but lately extended to private and Sunday-schools.

Believing, as we do, in the value of vaccination, such regulation would be unobjectionable were it not coupled with an act providing for compulsory attendance at school. This is an inconsistency, and, in our opinion, an injustice. Were parents allowed to choose between the value of an education and the dangers of vaccination no objection could be raised, for, in the absence of a general compulsory vaccination law, the dangers attending the presence in our midst of unvaccinated children would not be greater than that from unvaccinated adults—hardly as great, indeed, by reason of their more limited range of activity. In spite of this, we should endeavor to remove the ob-

jections of parents to the operation, and in no case are we justified in encouraging them to resist a regulation calculated for the general good, although it may, in isolated cases, work an apparent encroachment upon personal freedom of action.

The law, as applied to Sunday-schools, has not this feature of injustice attached, for there the parent may exercise his right of choice between religious inculcation and virus inoculation, and act accordingly.

Another action of the Board of Health, lately inaugurated, is the house-to-house visitation to urge the benefits of vaccination, and to perform it gratuitously, if so desired. Were this visitation confined to those districts and houses where, through poverty or ignorance, this precaution would seem most likely to have been neglected, it would commend itself to us all; but, as carried out, it decidedly encroaches upon the province of the private physician, and tends to minimize the value of his work and pauperize his patients. Besides this, where the publicly employed vaccine physician is expected to use 100 vaccine points daily, we can easily calculate about how much time can be given to each operation, deducting that consumed in going from house to house and urging the advantages of that which is offered. The dangers attending vaccination will, we fear, only be emphasized by the results of this plan. The universal distribution of short pamphlets, written for the people, giving facts and figures in reference to vaccination, and answering the calumnies against it, would, we think, be a much better method, followed, as it would be, by a house-to-house visitation in the poorer districts of the city. We should, however, place no obstacle in the way of carrying out the plan, except by seeking to retain our influence over our own patients, and to induce them to carry out the ostensible intentions of its originators.

The question as to the expediency and advantages of strictly quarantining every house, with all whom it may chance to contain at the time of the discovery of a doubtful or pronounced case of small-pox therein, is still open for discussion. The keeping isolated and under observation for a specified time, the time of incubation, those who may have become infected, is certainly a great advantage, but it implies such an encroachment upon the freedom of the individual that it should be carried out with greater care and judgment than it is, as we have reason to know. There are many instances where persons who could hardly by

any possibility have been exposed to the contagion have been compelled to remain in an infected house, not only at great inconvenience, but with great detriment to their business interests, as well as to their health. The procedure makes an unjust discrimination in favor of the physician and those who have taken an invalid out of the house. These are allowed to go their way, while many who have not been near the patient are obliged to remain. It can easily be imagined how this compulsory detention may act injuriously upon a nervous person, and reduce him almost to desperation, so that it is not to be wondered at if he makes every effort to escape. It is too often forgotten that the rights of the community for its own protection are only those delegated to it by the individuals composing it, and that the rights of these latter should, in every way possible, be respected. Were an examination made in each case of this kind, and only those detained who have been directly exposed to the contagion, while the others were allowed to depart after having been vaccinated, the measure would meet with more general and heartier support.

As it is, it cannot be regarded as fully guarding against further spread of the disease; for, should some one of those so detained develop the disease after a shorter period of incubation, the quarantine would properly have to be again extended to cover another incubation period, dating from this new case, and so on indefinitely. This, we believe, is not done.

Without being a lawyer, we would think that if an accidental visitor to a house should be quarantined there, and should, while there, take and succumb to the disease by reason of his detention, his relatives would have good grounds for claiming damages from the city.

Even here, although we cannot but think that the manner in which this regulation as to quarantine is carried out is unjust and oppressive, and that the regulation in itself is of questionable utility, we feel compelled to urge compliance with its provisions as tending to the welfare of the community at large.

Factionous opposition to well-intentioned actions of the powers that be can never be the duty of a physician. He should be willing to uphold the authority of the law, even when it runs counter to his own convictions, while, by his influence, private and public, he seeks to have it changed.

WM. H. BIGLER.

THE TETANUS INOCULATIONS.

SINCE the writing of our editorial on the St. Louis antitoxin-tetanus cases, the full report of the coroner's jury appointed to investigate the same has been made public. The facts elicited do not agree with previous statements. The horse from whom the serum was obtained died of tetanus on October 2, 1901. The last bleeding was made on September 30, 1901. The serum thus obtained was placed in bottles bearing the dates of August 24th and September 30th. Serum had previously been obtained from the same horse on August 24th, and was bottled with labels bearing that date. All of these serums were dispensed by the Board of Health. Examinations made by the experts conducting the investigation demonstrated that the samples bearing date of August 24th, and issued at that time, were non-toxic as to tetanus; that issued from the serum obtained September 30th was found to produce tetanus in the lower animals. It was furthermore discovered that it is the custom of the authorities to dispense the antitoxin without properly testing it as to the presence of the toxins of tetanus, or even as to its antitoxic power over diphtheria. For example, serum dated October 23d came into the hands of the committee on November 1st, the period elapsing between these dates being altogether too short for making any such investigations.

The result of the investigation shows that the development of tetanus was not the fault of the generally-accepted principles of bacteriology. On the contrary, they show criminal negligence on the part of those who prepared the antitoxin. That such negligence is common among manufacturers generally, we do not believe, for their employees depend for tenure of office upon the efficiency with which they perform their duties. That is business. In the case of Board of Health antitoxin, things are different. Tenure of office depends upon ability as a political worker. The official is more concerned over carrying his division for his party than for excellence in workmanship. That is politics.

It is recognized that unavoidable accidents may occur, and that horses used for manufacturing antitoxin may contract tetanus. But when such accidents do occur, there is no excuse whatever for the products obtained from these animals being dispensed. They should be condemned and destroyed without any further examination. It should be a general rule that all antitoxin must be tested not only for its antitoxic power, but also for the presence of the toxins of tetanus, and for accidental micro-organisms which may have gained access to it. In view of the importance of the subject, laws governing this point should be enacted. The penalties attached should be severe, because of the serious results following upon neglect of the proper precautions. Carelessness such as that practiced by the responsible parties in St. Louis is murder.

Since the appearance of our December issue we have received the official report of the Camden Board of Health relating to the tetanus cases following vaccination. This report demonstrates the following facts: 1. That samples of vaccine purchased in the open market, and representing the products of all firms doing business in Camden, have been examined by the State Bacteriologist at Trenton, N. J., and have been found free from tetanus germs. 2. That in each of the cases reported, vaccination was properly performed. 3. That other cases of tetanus than those occurring after vaccination have been reported in Camden and environs. 4. That in no instance did the tetanus appear until three to four weeks after vaccination; had the tetanus germs been introduced with the virus, that disease would have become manifest within nine days. 5. Inoculation experiments on animals failed to induce tetanus. 6. That over a half-million people have been vaccinated in Philadelphia, without the incidence of a single case of tetanus following. We were in error in stating that there was one such case, our mistake arising from the acceptance of a statement made in the *North American*. 7. That the present conditions favor the occurrence of tetanus in Camden, these conditions being the long period of dry weather and high winds, and the resulting contamination of the atmosphere with the dust from the earth, stables, etc., these being the normal habitat of the tetanus germs.

CLARENCE BARTLETT.

GLEANINGS.

A SHOT IN THE ANTERIOR CHAMBER FOR EIGHT YEARS.—The patient was a man who had been shot in the face eight years previously, and one of the pellets had penetrated the eye-ball. During all this time one of the shot had remained out of sight in the anterior chamber, without giving rise to any inflammation and without in any way affecting vision. The pellet must have expended its force on passing through the cornea, for it apparently dropped to the bottom of the anterior chamber.

Whether the iris was perforated was not determined. There was probably no perforation of the lens, for there was only a slight circumscribed clouding of the latter. There was a slight choroido-retinal rupture, which must have been the result of the counter-stroke. The case, by the way, had been characterized by strabismus concomitans.

He thinks this condition was due to the pellets which were imbedded in the neighborhood of the inner orbital border. In other words, that an injury of the tendon of the internal rectus had been caused by these pellets on the way into the orbit, and that, as a result, a certain amount of cicatricial contraction followed, which had led to shortening of the muscle and strabismus. In the same way he explained a slight ptosis which was present as being due to a lesion of the levator or of a nerve branch. The absence of anatomical changes in the eye showed that the pellet was sterile, and that lead can give rise to no trouble in this locality.—Burstenbinder, M.D., in *Archiv für Ophthalmologie*.

William Spencer, M.D.

A CASE OF PRIMARY SYPHILITIC AFFECTION OF THE LACHRYMAL GLAND.—Foerster, in the first edition of Graefesalmisch, asserted that the lachrymal gland was the only organ of the eye which is not attacked by syphilis. Since then a few cases of gumma and syphilitic inflammation of the gland were described, but not a primary one, as this, in a boy of fourteen. The upper lid red, swollen, oedematous, livid. A sharply defined, hard, smooth tumor is felt above the tarsus, its posterior surface 1.5 cm. long, 1 cm. wide. Conjunctiva is the seat of yellowish-gray nodules of the size of the head of a pin, forming irregular patches by confluence. Vision normal. Swelling of pre-auricular and sub-maxillary glands. Apex of left lung gives dull sound on percussion. Diagnosis: tuberculosis of the lachrymal gland, which is removed; also the pre-auricular and sub-maxillary glands. The wound healed *per primam*. After four weeks, papulo-maculous exanthema and general swelling of the lymphatic glands occurred, and a week later syphilitic periostitis.

Healed under anti-syphilitic treatment. After several months, swelling of several lymphatic glands and papules at anus. The microscopic examination of the tumor revealed no tuberculosis, but proliferation of tissue which

was considered syphilitic. The infection started either from the conjunctiva or directly in the lachrymal gland through the secretory ducts, without creating sclerosis of the conjunctiva.—E. Anargyros, M.D. (*Ibidem*, from the clinic of Professor Fuchs.)

William Spencer, M.D.

SYMPTOMS POINTING TO THE NECESSITY FOR THE OPERATIVE INTERFERENCE IN MASTOID SUPPURATION.—Phillips.—An early diagnosis is of the greatest importance, as it offers the best possible chance of recovery. Perhaps the most marked symptom of mastoid involvement is pain. This pain usually comes on some time after the excruciating pain which precedes suppuration of the middle ear has passed away, and after the discharge from the ruptured or incised drum has been established. It is a dull, heavy pain, not localized, but rather diffused over the surface of the temporal bone. With this pain there is a sensation of fullness, heaviness, and pressure over the entire parietal region. Tenderness to pressure is also another important symptom. This tenderness is usually marked at the tip of the mastoid, but is more significant when it is present higher up, just over the mastoid antrum. The temperature is not to be relied on. The facial expression is characteristic, the position being with head forward and leaning to the sound side, with an unhappy expression in the face. External periostitis is a positive indication for operation. Other symptoms, such as rigors, vertigo, choked disk, facial paralysis, uneven pupils, typhoid state, would lead us to say that the disease had extended beyond the ear.

At times we find evidence of mastoid involvement which will disappear as soon as the drum is freely incised and the ear drained, hence free drainage is held out to be a valuable preventive of mastoid suppuration. When a permanent remission of symptoms is not brought about by free drainage, or by cold applications or poultices, the sooner the operation is done the better for the patient.—*American Journal of the Medical Sciences*, Dec., 1901.

William F. Baker, A.M., M.D.

THE TREATMENT OF AORTIC ANEURYSM BY MEANS OF SILVER WIRE AND ELECTRICITY.—Freeman.—Conclusions reached from the study of two cases are: (a) considering the inefficiency of medical treatment and comparative efficiency of the use of the silver wire and electricity, it is probably better to proceed to the latter at once; (b) soft, undrawn, unalloyed silver wire, devoid of spring, is preferable to the hard, highly drawn wire, alloyed with copper and full of spring; (c) advantages are to be found in the large amount of wire used; (d) a strong electric current is to be preferred; (e) the canula through which the wire is to be introduced should be placed just within the wall, and no further; (f) there is little danger of bursting the aneurysm from increased pressure due to the coagulation in that portion of the sac.

Technique is as follows: asepsis, local anæsthesia, insertion into the aneurysm of an insulated needle, hollow, through which is introduced silver wire. From 3 to 20 feet are to be used, according to the size of the cavity. The wire is then attached to the positive pole of a galvanic battery and the negative applied to the back of the neck. A current of 70 to 80 milliamperes passed for from one-half to one hour and one-half. The wire is then cut close to the skin and sunk beneath the surface.—*American Journal of the Medical Sciences*, Dec., 1901.

William F. Baker, A.M., M.D.

THE USE OF VERATRUM VIRIDE IN PNEUMONIA.—After investigation Stephens comes to the conclusion that veratrum "is more efficacious in pneumonia than quinine in ague." It has a direct action on the pneumonic process by lowering the pressure in the arteries and lessening the accumulation of toxic products. In summing up the action of the drug he calls attention to the fact that the medicine has a particular predilection for the heart and arteries, its primary action being a spinal and arterial depressant, thereby lessening the force and frequency of the pulse rate and diminishing the frequency of respiration. Veratrum possesses also diaphoretic properties which in pneumonia, by its tendency to lessen the action of the heart and arteries, and at the same time opening the transpiratory glands, is a proper auxiliary in the elimination of toxins. There is also an increased flow of urine, and the bowels, which are usually constipated, are somewhat relaxed. Wood says of the drug that it is a powerful spinal and arterial depressant, exerting little or no influence on the cerebral centres; it lowers the pulse rate by a direct action on the muscle, and stimulates the inhibitory nerves.

When the medicine produces nausea it is usually due to an overdose, and can be remedied best by discontinuing for a few doses. In the presence of nausea and vomiting the drug is contraindicated.—*Therapeutic Gazette*, Nov. 15, 1901.

William F. Baker, A.M., M.D.

SULPHUR IN THE TREATMENT OF DYSENTERY.—Richmond, as a result of his experience in the treatment of dysentery at the Imperial Yeomanry Hospital, at Deelfontain, South Africa, came to the conclusion that ipecacuanha, "guarded" by opium and combined with warmth and rest in bed, formed the best treatment. Certain cases ultimately died, however, and as a result he turned to other remedies, notably sulphur. In every case treated with sulphur a cure resulted, and there seemed to be little or no tendency to relapses or chronic conditions of alternating diarrhoea and constipation. Twenty grains of sublimed sulphur combined with five grains of Dover's powder were ordered every four hours, and as a result the patients became much more comfortable, diarrhoea and distressing tenesmus were relieved at once, and as a rule the passage of blood and mucus stopped within two days. "The precise mode of action of sulphur in the intestines is more or less a matter of conjecture; it is, however, reasonable to believe that sulphuretted hydrogen and other sulphur acids are formed and inhibit the growth of the micro-organism of dysentery. . . . Sulphur is, from its solidity and non-absorbability, an ideal intestinal antiseptic; that it passes along the whole intestinal tract is shown from the fact that it can be seen suspended as a yellow powder in watery motions."—*The Lancet*, Nov. 23, 1901.

F. Mortimer Lawrence, M.D.

A SIMPLE METHOD FOR DETECTING THE DIPHTHERIA BACILLUS.—Pitfield, while regarding the culture method as best for the diagnosis of diphtheria, acknowledges the difficulty of applying it in the country and where there are no laboratories. He has found that a simple staining and microscopical examination of the throat exudate is quite satisfactory. His method is to take a probe tipped with absorbent cotton and rub it firmly on the exudate in the throat. The swab is then taken to the office, where a clean glass slide is moistened with a drop of water, and upon its surface the swab is rubbed.

The slide is then dried by passing it through a flame three times, warming it sufficiently to fix the preparation, but avoiding overheating.

Three staining solutions are required: (a) silver nitrate, 5 grammes; distilled water, 5 cubic centimeters; and a saturated alcoholic solution of fuchsin, 3 cubic centimeters; (b) pyrogallie acid, 1 gramme; 10 per cent. sodium hydrate in water, 5 cubic centimeters; and distilled water, 10 cubic centimeters; (c) carbol fuchsin solution, 10 drops; and distilled water, 10 cubic centimeters.

Upon the film to be examined a small quantity of solution (a) is poured, heated to boiling, allowed to remain on one minute, and then washed off. The specimen is then treated in the same manner with solution (b), and finally a small quantity of solution (c) is poured on, allowed to remain for two minutes, and then washed off and the glass allowed to dry. On examination the organisms will appear of a delicate pink color, of slightly uneven shades, corresponding to the density of the protoplasm. At one or both ends, and often in the middle, brilliant, shining black points appear, which stand out very sharp and clear. The cell membrane stains a gray-brown of very light shade. Dr. Pitfield states that the morphology of the diphtheria bacillus varies greatly. In organisms of very low virulence the bacilli exhibit these points at the very end of the rod; they appear simply attached; there may be a small point in the middle. Other bacilli of greater virulence show these points well within the protoplasm, but yet strictly polar as to their position.

If these point-bearing bacilli are found in the fibrin, one can be very certain that the case is diphtheritic. Other organisms are found in this way, but the peculiar chromatin granules distinguish the diphtheria bacillus. The author has verified many of his observations by cultures, and has found that this simple, direct method of examining the exudate is perfectly reliable.—*University of Pennsylvania Medical Bulletin*, Sept., 1901.

F. Mortimer Lawrence, M.D.

KOPLIK'S SPOTS IN MEASLES.—Lorand (*Jahr. f. Kinderheilk.*, June, 1901) gives the results of two years' experience at the Children's Hospital, Budapest, of the value of Koplik's spots in the differential diagnosis and prophylaxis of measles. During 1899 and 1900 the mouth of every child in the out-patients' room was examined. Over 30,000 cases passed through the department in that time, and in no other disease but measles was the sign found to be present. Among these out-patients there were 348 measles cases, and Koplik's spots were absent in only 19. Among 144 in-patients with measles, 57 showed Koplik's spots on admission and developed the rash on the skin in from one to five days later on. The others had the skin eruption already out; of these, 8 were without the sign, but then the eruption had been out for two days or more. Lorand quoted Fruitnight, of New York, and Schmid, of Gratz, who were able by this sign to distinguish with certainty between measles and röteln during an epidemic of the two diseases.

Koplik and others (for example, Slawyk, of Berlin) consider the spots as pathognomonic; but Widowitz, of Gratz, while admitting their great value, says they occur, although rarely, in röteln, angina lacunaris, and respiratory catarrhs as well. Lorand describes the locality for finding the spots, that is,

the buccal mucous membrane opposite the pre-molar teeth of the lower jaw. They never appear upon the palate, tonsils, or fauces, but red spots with central vesicles may be found in these places very frequently in measles, and also many other inflammatory diseases. Koplik's spots are now well known as tiny, fine, opal dots, looking as if scattered by a spray over the glistening buccal mucous membrane. They require a good white light for their detection, and cannot be seen by lamplight. The base they lie on may or may not be reddened, their size is uniform, their number varies, and they never coalesce. They are composed of heaped-up epithelial cells. They last three or four days, disappearing with the full efflorescence of the measles rash upon the face. They were known and described in 1854 (*Virchow's Archiv*, vol. vii), but it was Koplik who first really appreciated their value in 1896.—*Brit. Med. Journal*, Nov. 23, 1901.

F. Mortimer Lawrence, M.D.

A NEW METHOD OF VAGINAL HYSTERECTOMY.—(Döderlein.)—The operation begins with the usual incision through the mucous membrane around the cervix. The cervix is then grasped on each side with a Muzeux forceps and drawn firmly up toward the symphysis pubis. One blade of a straight scissors is introduced into the cervical canal, and a median incision is made posteriorly, which divides both the cervix and vaginal wall and opens the cul-de-sac of Douglas. The vagina is now cut away on each side at its attachment to the cervix, and the opening into the peritoneal cavity thereby enlarged. The entire thickness of the cut uterine wall on each side is now seized with smaller four-pronged Muzeux forceps and drawn into the vaginal opening as the bisection of the uterus is continued from behind up over the fundus until the vesico-uterine fold of the peritoneum is reached. Eight Muzeux forceps on each half of the uterus control the hæmorrhage, and make it easy to manipulate the halves of the uterus. These segments of the uterus are now drawn downwards and backwards, which puts on the stretch the loose cellular tissue between the cervix and the bladder, and makes it very easy to cut away the cervix without any danger to the retracted bladder. This method makes it easy to resect a large portion of the vagina, or to lay the parametrium free even out to the pelvic wall, if desired, in carcinoma, by drawing the segment of the uterus down and to the opposite side, and by blunt dissection under the folds of the peritoneum, if necessary. No ligatures or clamps on the blood-vessel have been required up to this time. The field of operation is clearly visible and accessible. The blood-vessels are easily isolated and tied, and tubes or ovaries can be left or tied, as circumstances require. The subsequent closure of the vaginal vault is similar to the usual methods.—*Archiv für Gynakologie*, Bd. 63, H. 1 and 2, 1901.

George R. Southwick, M.D.

THE TREATMENT AND STATISTICS OF ECLAMPSIA.—(Glockner.)—The writer reports 146 cases, with 26 deaths, and 1 case dead when brought to the hospital. There were 26 post-mortems, and the kidneys were reported diseased in 25 cases. The pathological alterations were recent in all cases, and in about one-quarter of the cases older processes were present. The twenty-sixth case, and the only one in which no alterations of the kidneys were reported, died eleven days post-partum from gangrene of the lungs. Yet before the attack of eclampsia there was a high percentage of albumin (30 per 1000,

Esbach), and numerous cylinders were present in the sediment. The kidney may possibly have recovered during the eleven days. There were macroscopical alterations of the liver in 77 per cent. of the autopsies, which agrees well with Schmorl's observations. (Edema of the brain was nearly as frequent (18 cases). The total mortality in all cases was 17.24 per cent., excluding complications not connected with eclampsia, such as tuberculosis of the lungs, sepsis, etc.; and in 3 cases brought moribund into the hospital the mortality was 15.49 per cent. The mortality for primiparæ was 19.8 per cent., and for multiparæ 10.3 per cent., which figures accord with the results of Zweifel and Schreiber, and are contrary to the statistics of Schaula and Löhlein. Seventy-seven cases were delivered by artificial dilatation and 14 (18.18 per cent.) died. The mortality was 10 per cent. for cases of twins, and 21 per cent. for mothers of contracted pelvises. The persistence of coma after convulsions is important for prognosis. In 21 of the fatal cases consciousness did not return. Eclampsia, as the immediate cause of death, occurred but once in the other 6 cases. Pneumonia was present in 22 cases, and played an important part in the development of secondary pneumonia. A high increase of temperature during the attacks is prognostically unfavorable. In 18 fatal cases in which the temperature was taken during the attacks, 8 (44.4 per cent.) showed a temperature of 39.0° and more, while of 86 recoveries only 6 (7 per cent.) showed such temperatures. The oft-repeated statement that eclamptics were especially endangered by puerperal sepsis could not be confirmed. The ante-partum attacks ceased post-partum, whether labor was completed spontaneously or operatively, in 41.2 per cent. of the cases. The mortality of the children was 43.59 per cent., and about half of these (48.5) were premature. The relation of the frequency of the attacks on foetal life showed that among the living children there was an average of 4.86 attacks ante-mortem, and of the children born dead 8 attacks. Only 17 per cent. of the children were born alive after 10 attacks. Venesection is among the therapeutic measures practiced in this clinic (Leipsic). It is employed for eclampsia in puerperio, in which numerous convulsions occur in rapid succession after the birth of the child, with a pulse of high tension, unless a considerable quantity of blood has been lost during labor. In 43 cases of this kind there was no recurrence in 7 cases, 1 recurrence in 7 cases, 2 in 3 cases, 4 in 4 cases, and a larger number in 22 cases. Treatment for ante-partum eclampsia consists in early, rapid delivery, and careful delivery in deep narcosis. Chloroform was used previous to 1896, and since then ether almost exclusively. Dilatation of the maternal soft parts has been accomplished partly by dilatation with rubber bags, partly by incisions about the external os uteri, and partly by combination of both methods. The latter has been used both with a dilated and an undilated cervix, and in primipara as well as multipara. The incisions in the cervix were made by seizing the border with two of Billroth's clamp-forceps and cutting between them. The clamps are allowed to remain for a few moments, to prevent excessive bleeding from the cut surfaces. These cervix incisions were not sutured, as a rule, after labor. If the head is at the brim and the child fairly movable, version, with immediate extraction, is immediately performed. If the child dies during the operation, perforation of the after-coming head is performed if it offers any considerable obstacle to delivery. In all cases of eclampsia the stomach is frequently washed out after labor with vegetable acids, usually tartaric acid. Saline infusion after venesection is employed. Hydro-thera-

peutic measures are employed, such as hot packs, warm baths, with external douching, as well as morphine. Special directions are given that the patient shall not receive anything to swallow until consciousness has returned. The throat is wiped out to avoid the aspiration of saliva. The measures taken for delivery will accomplish it in less than an hour, which is less time than is necessary for a laparotomy, and far safer, in the end, than Cæsarian section for eclampsia, which has been recently proposed.—*Archiv für Gynäkologie*, Bd. 63, H. 1 and 2, 1901.

George R. Southwick, M.D.

THE TREATMENT OF POST-OPERATIVE GENERAL PERITONITIS.—(Hintze.)—Recovery is sometimes possible even in apparently unfavorable cases of peritonitis. Opening the abdominal cavity freely and removal of the exudate, with subsequent drainage, is by far the most important aid to recovery. The earlier it is performed the better is the prognosis. The operation should be performed as simply as possible, and be limited to the emptying and drainage of the exudate. Further experience is necessary to determine whether this is best accomplished by thorough irrigation or dry aseptic cleansing. Stimulants should be used very freely after operation, and every effort made to build up the system. Nothing should be given by the mouth while nausea persists, and bland, nutritive enemata must be given. The heart should be stimulated and blood-pressure increased by camphor, digitalis and saline infusions. Toxic substances should be eliminated from the body as soon as possible. Normal saline injections, either subcutaneous or intravenous, are useful for this purpose. The intestinal contents of such patients possess increased virulence, and should be removed by irrigation or catharsis. Small, frequent doses of calomel are useful for this purpose. Maccosh went so far as to inject into the incised bowel at the time of the operation a solution of sulphate of magnesia to excite peristaltic action.—*Archiv für Gynäkologie*, Bd. 63, H. 1 and 2, 1901.

George R. Southwick, M.D.

KUESTER'S SIGN OF DERMOID OF THE OVARY.—(Bruer.)—Kuester's sign consists in the position of a small and apparently cystic tumor near the median line in front of the uterus, and the return of it to its former position after pushing it to one side. The writer finds that it is not absolutely characteristic for small dermoids of the ovary without adhesions, and that it can be used only as an adjuvant of dermoid cysts.—*Centralblatt für Gynäkologie*, No. 44.

George R. Southwick, M.D.

A FOREIGN BODY AS AN OBSTACLE TO LABOR.—(Czarnechi.)—The writer was called to a woman in labor, 27 years old, who had aborted at the fifth month, a year and a half previously, and found a tin box, four inches long and an inch and a half wide, between the head and os uteri. The woman stated that she had introduced it into the vagina when she was twelve years old, at the first menstruation, to prevent further loss of blood, and was unable to remove it afterwards. The foreign body could always be felt in the vagina until the abortion took place, but not afterwards, when it had undoubtedly slipped into the uterine cavity through the dilated cervical canal. The patient had not suffered from it. Her husband first knew of it at the time of labor. The writer removed the cover, and then the box proper, with bone forceps. Labor

did not progress after waiting nine hours, and examination showed two rigid bands of scar tissue in the right side of the cervix. These were divided, the os divided normally, and labor was completed by bone forceps operation. Recovery was uneventful.—*Deutsche Med. Wochenschrift*, 1901, No. 33.

George R. Southwick, M.D.

ESERINE IN INTESTINAL ATONY.—Dr. Von Noorden has obtained good results with eserine in excessive tympanites. He was led to use it on account of it being employed in veterinary medicine as an evacuant of the intestines, for it favors peristalsis. In five cases of tympanites, either following operation or complicating infectious diseases, as typhoid or gonococcal salpingitis, he rapidly brought about a disappearance of meteorism by prescribing the salicylate of eserine in doses of .000–.003 daily, divided into two, three or four parts. On account of the changes which the solution of the drug undergoes, it is best to employ the powder. To avoid overdosing, it is wise not to give more than one mgm. at a time, and no more than three mgms. per diem, and only to reach these doses gradually. If, however, toxic symptoms supervene, they may be removed by hypodermatic injections of atropine.—*La Semaine Medicale*, No. 44, 1901. (A very toxic drug, which is liable to bring about paralysis of respiration.)

Frank H. Pritchard, M.D.

SYMPHYSIS OF THE PERICARDIUM AND ASYSTOLIA IN CHILDREN.—Prof. Marfan asserts that in a child over five to six years repeated attacks of asystolia, with hypertrophy of the heart, is sufficient to justify a diagnosis of pericardiac symphysis. This condition is seen relatively more frequently in children than in adults, and is due either to rheumatism or tuberculosis of the pericardium. In the former case the heart is large, hypertrophic, and dilated, usually with endocarditic and often with mural changes, while with the tuberculous variety the heart is normal or even diminished in volume, though in both forms the pericardial layers are more or less adherent. Both forms produce asystolia and affect the liver. The writer points out the striking difference between symphysis and chronic valvular affections in children, for he never has observed a case of asystolia after rheumatic endocarditis in a child. Chronic pericarditis is not only more frequent but also more serious in children, for it more frequently brings about adhesion of the pericardial layers, with consequent asystolia. Only in one condition may another cause be at work—when a congenital heart anomaly is complicated by a later endocarditis. He has never seen a case of symphysis in a child which did not cause asystolia. This is so characteristic that if no other signs, as increased volume of the heart, abnormal movements in the pericardial region, and especially a systolic drawing in of the area of the apex, which has been looked on as pathognomonic, be present, still a diagnosis of symphysis may be made. In the tuberculous variety these signs are not present, neither are there dyspnoea nor palpitation, while the heart-sounds are weak or nearly always without abnormal sound, in striking contradistinction to rheumatic symphysis, where there are dyspnoea, palpitation and violent murmurs. But both forms may give rise to asystolia, œdema, cyanosis and enlarged liver (*Stauungsleber*).

This latter sign, the enlarged liver, he regards as particularly characteristic of pericarditic asystolia in children, for, though it may be seen in adults, yet after repeated attacks cirrhotic changes set in, with ascites, enlarged spleen

and urobilinuria. In the tubercular form, the liver, besides being gorged, may present tuberculous changes. As to the differences between asystolia in children and adults, he states that in children the heart's action is generally regular, while in adults it is often arrhythmic; signs of tricuspidal incompetency, as well of pulmonary infarcts, are rare in children, while the liver symptoms and signs predominate.

The end is nearly always death. Therapeutically, one may try the various heart tonics—first of all, digitalis, which he prefers in a maceration, for heating destroys one of its active principles. To children of five or six years he gives 20–40 cgms. of powdered digitalis, macerated in 60–100 gms. of cold water. This dose should be given once a day, but not longer than five days in succession. If no improvement follow, one had better turn to, theobromine, in doses of 75 cgms. a day to a child under six years; 1–1½ gms. to children over six. If this also fail, one may try caffein or strophanthus. Quiet of both mind and body is needful. A blister to the præcordium may be employed; calomel for the cirrhosis is of service. Possibly surgery, as suggested by Delorme in 1898, may in the future bring these patients help.—*Hospitalstidende*, No. 37, 1901.

Frank H. Pritchard, M.D.

BEER IN THE TREATMENT OF OBSTINATE VOMITING.—Dr. L. Kolipinski, in cases of obstinate vomiting in women who are not addicted to alcoholic drinks, has gotten good results from the ingestion of one or two bottles of a light beer. In several cases he has observed that a glass of beer every half hour for a little while has brought about relief of these attacks of nausea, with bilious vomiting, vertigo and headache, which usher in the grippe. He also recommends it in catarrh of the stomach, with great gastric intolerance, repeated vomiting, acute pain, prostration, etc.—*La Semaine Medicale*, No. 44, 1901. (I can confirm this from experience.)

Frank H. Pritchard, M.D.

A FORM OF CHRONIC PARENCHYMATOUS NEPHRITIS IN TUBERCULOUS PERSONS.—Dr. L. Bernard and Prof. L. Landouzy differentiate between a local renal tuberculosis and a nephritis in a tuberculous individual, without any bacillary localization in the kidneys themselves. There are several such forms of kidney disease, but the writers have only studied one. This is a chronic parenchymatous inflammation of the kidney, due to the toxin of the disease, usually of pulmonary localization. They assert that it is quite frequently an accompaniment of pulmonary tuberculosis, and present six cases. As a rule, the disease is insidious in its development in seemingly well or evidently tuberculous persons. At first the patient complains of loss of strength, loses weight, emaciates; he notices here and there fugitive œdema; the urine is scanty and contains albumin. There may be pain in the loins, disturbances of digestion, and at times headache, but usually none of the well-known "minor uremic" symptoms (of Dieulafoy) are noted. It is interesting to know that an examination may reveal an incipient localization of the disease, tuberculosis, in the lungs, though it usually is but slight. The writers have employed both cryoscopy and the methylene-blue method. Both Bartels and Lancereaux have observed a connection between tuberculosis and chronic parenchymatous nephritis. Pathologico-anatomically the lesion is the large, white kidney, with a tendency to damage the tubuli contorti, while the interstitial tissue is unaffected. The writers, like Lancereaux, compare this

form of renal trouble with tuberculosis to the renal lesions of syphilitic origin. The nephritis is the specific result of an infection, be it syphilitic or tuberculous, and this disease seems to have an affinity for the kidneys. All the toxins of tuberculosis appear to have a tendency to attack the renal epithelium, while some have been described which affect the other tissues of the kidneys. One should, in a case of chronic parenchymatous nephritis, not be satisfied with the diagnosis of nephritis, but seek for a tuberculous focus, preferably in the lungs, for he asserts that tuberculosis is of greater etiological importance than has been heretofore thought.—*Hospitalstidende*, No. 37, 1901. (Prof. Lépine, of Lyons, asserts that there is a stage of pulmonary tuberculosis when albumin may be found in the urine, due to irritation of the renal epithelium by excretion of the tubercular toxins.)

Frank H. Pritchard, M.D.

A BACTERIOLOGICAL EXAMINATION OF CLINICAL THERMOMETERS.—Dr. Rosenberg, of Philadelphia, has examined a number of clinical thermometers which had been used, without disinfection, in different patients' mouths, having in view the possibility of transmitting disease by their careless use. In eight cases where thermometers had been used for twenty-four to fifty-six hours to take temperatures in the mouth in patients with various diseases, as broncho-pneumonia, diphtheria, tuberculosis, rheumatism, puerperal fever; and in nineteen others, where the temperature was taken in the axilla, the instruments had not been disinfected. As a control test, a third series of experiments was made, where the thermometer was immediately after use washed in water, plunged into a solution of bichloride of mercury for two minutes, and then dried and placed in its case. The first series of eight gave no colonies, the second numerous ones, chiefly of the pyogenic staphylococci, associated with other micro-organisms. Hence he thinks it necessary to disinfect a thermometer after using.—*La Semaine Médicale*, No. 40, 1901.

Frank H. Pritchard, M.D.

THE RELATION OF TUBERCULOSIS IN CATTLE AND MAN.—Prof. Baumgarten has written an article on this subject, which has roused much interest since Koch's utterances in London. He asserts that there is not to be found in the literature a single conclusive proof that an ox has been infected by human tuberculosis. He then communicates the experiments of a physician, now dead, who, some twenty years ago, attempted to inoculate human beings with the bacilli of tuberculous cows. Led by Rokitansky's idea that there is an antagonism between cancer and tuberculosis, he injected tubercle-bacilli subcutaneously to arrest the growth of cancers. As he had no human tubercle-bacilli, he took those of oxen, and, as a prosector, he had opportunity to examine post-mortem six cases where the inoculations had been done. Though a considerable number of bacilli were injected, yet only small, abscess-like formations were noted which had nearly healed, and the results were negative. Therefore, though Rokitansky's assertion of the antagonism of cancer and tuberculosis has long since been disproved, yet he regards Koch as in the right when he says that bovine tuberculosis is but little dangerous to man.

The bacillus itself, both of bovine and human tuberculosis, is identical, but each from its different media has lost its pathogenic power over the culture medium, though it may be possible to revive this by experimentation.

Though he does not regard bovine tuberculosis as dangerous to man, yet he would hardly advise a relaxation of the usual precautionary measures, for the possibility of the transmission of contagion cannot be denied.—*Hospital-studende*, No. 42, 1901.

Frank H. Pritchard, M.D.

A CASE OF HYSTERIC BREAST.—Dr. Lannois, at the eleventh meeting of French Alienists and Neurologists, presented the photograph of a woman affected with a hysteric breast. While her left mamma is relatively small and flabby, the right was voluminous, pear-shaped and tense to the feel, with a more or less marked areola. Pressure of the breast *en masse* and pinching of the areola was liable to be hysterogenic. The patient complained of a feeling of weight and lancinating pain, which at times would be very violent, so that she entered the hospital thinking that she was suffering from a tumor. Of course she was advised against intervention. The affection was recognized as of hysteric origin, and it may be at times the only symptom of the disease—a monosymptomatic hysteria. He thinks that both surgeons and neurologists should bear this form of disease in mind.—*Le Progrès Medical*, No. 35, 1901.

Frank H. Pritchard, M.D.

INOCULATION WITH TUBERCULOSIS.—Prof. O. Lassar, of Berlin, as proof of the ease with which tuberculosis may be inoculated under the skin, mentions the case of a woman now of thirty-five years, who, when she was a school-girl, often had her ears pinched by her teacher. Since her childhood she has had lupus of the lobe of one ear. As the teacher was notoriously consumptive, he undoubtedly inoculated her ear by his fingers, soiled with his tuberculous sputum.—*Berliner Klinische Wochenschrift*, No. 31, 1901.

Frank H. Pritchard, M.D.

THE SIMULTANEOUS EMPLOYMENT OF ANALGESIA OBTAINED BY SPINAL COCAINIZATION AND ETHER OR CHLOROFORM NARCOSIS.—Fowler (Brooklyn) suggests the use of ether or a small amount of chloroform, for the purpose of producing a slight narcosis prior to the lumbar puncture, or of combining narcosis for the purpose of obliterating the touch sensation and the mental disturbances with the analgesic effects of spinal cocaineization.

One of the chief objections to the employment of spinal analgesia is the fact that in some individuals there is a "mental shock," so called, arising from the dread the patient feels of suffering pain during the operation, in spite of the assurances of the surgeon to the contrary. This difficulty can be nicely overcome by the combination of anæsthetization by ether or chloroform with the spinal cocaineization. Very little of the anæsthetic agent is necessary, just enough to quiet the patient and dull the sensibility. The author has tried the method three times with pleasing results. In two chloroform was given, and in the other ether. The operations were: Vaginal section for pyosalpingitis, occupying twenty minutes; resection of two ribs, and decortication of the lung, of fifty minutes' duration; and a posterior gastro-enterostomy for carcinoma, taking in all one hour.—*American Medicine*, Oct. 19, 1901.

Gustave A. Van Lennep, M.D.

MILTON'S METHOD OF EXPOSING THE ANTERIOR MEDIASTINUM MODIFIED FOR LIGATURE OF THE INNOMINATE ARTERY.—Curtis (New York) reports a case of ligation of the innominate artery in a man fifty-five years of age for

aneurysm affecting the right sub-clavian and axillary arteries. The vessel was exposed by a modification of Milton's method of opening the anterior mediastinum by splitting the sternum. Curtis split the manubrium only, and then divided the bone transversely at the lower border of the first intercostal space. The two halves could be separated nearly two inches. A double, heavy, chromicized catgut ligature was used, the threads laid side by side, and tied simultaneously tight enough to arrest pulsation, and not so as to cut the internal coat. A second ligature was passed through the same opening beneath the artery and tied obliquely, a quarter of an inch distally from the first. The two halves of the bone were held together by two silver wire sutures. The patient made a good recovery, but pulsation returned in the aneurysm, necessitating additional ligatures to the carotid, and the first and second portions of the subclavian attacked by dividing the clavicle between the inner and middle thirds. Seven months later the patient was in good health, and with no trace of the aneurysm. The steps of the Curtis operation are :

1. A median incision is made from the larynx to the middle of the sternum or lower, dividing the deep fascia above, and the periosteum, also, below.

2. The sternohyoid and the sternothyroid muscles are followed to their sternal insertions, retractors being placed so as to draw the soft parts at the base of the neck widely apart.

3. A transverse incision is made through the periosteum along the upper border of the manubrium, and the periosteum and muscles detached from the posterior surface of the bone by blunt elevators and the finger as far as can be reached.

4. The ordinary amputation saw is then applied to the bone in the line of the vertical incision in the periosteum, the soft parts in the neck and behind the sternum being protected by flat metal strips. The saw is held with its point turned towards the neck and its handle towards the ensiform cartilage. It should cut most deeply above, and entirely divide the manubrium at its upper border, the cut being more shallow below, and only grooving the bone at its lower end. This obliquity of the cut necessitates the long-skin incision which has been described.

5. A stout chisel is then applied in the saw-cut at the superior border of the manubrium, and the thin layer of undivided bone on the posterior surface is made to give way as the wedge action of the chisel forces the two halves apart.

6. The skin being well retracted, a transverse incision is made in the periosteum across the face of the bone at the level of the first or second intercostal space, and the chisel is applied in this line directly obliquely outward from the middle line on each side so as to divide each half of the bone from the body of the sternum. The instrument must not be allowed to cut entirely through the bone at the outer border for fear of injury to the pleura or internal mammary artery. Both lie a little distance from the bone, so that the danger of wounding them is not great.

7. Strong retractors are then inserted in the median saw-cut, and with a little force the two halves can be sufficiently separated to allow access to the periosteum, which should be carefully incised or scratched through with the point of the knife, beginning above where the danger of damage to the sub-

jacent parts is least. As the periosteum is divided, the halves of the bone can be more widely separated, and this interval gradually extends from an inch to nearly twice that distance as the steady strong traction is maintained during the subsequent operation. A separation of three centimeters can be obtained in any case, and this is abundant. The small intercostal branches of the internal mammary artery are somewhat tortuous and sufficiently long to allow free motion of the bone without receiving injury.

8. The muscles and fascia are then divided by blunt dissection, or with forceps and scissors, in the median line, beginning above, double ligatures being applied to the veins which cross the line of incision. In the case reported the nerves were not seen at all; and even in a ligature of the first part of the subclavian by this method the author does not believe there would be any danger to the recurrent laryngeal nerve, because the sheath of the vessel would be opened as soon as exposed, and the subsequent manipulations would take place within the sheath completely separated from the nerve.—*Annals of Surgery*, October, 1901.

Gustave A. Van Lennep, M.D.

EARLY DIAGNOSIS AND OPERATIVE TREATMENT OF DIFFUSE, PURULENT PERITONITIS OF APPENDICAL ORIGIN.—Dr. Bauer, of Malmoe, Denmark, at the fifth meeting of the Scandinavian surgeons, read a paper on this subject. He first discussed "peritoneal irritation," which has by different writers been so variously described. Some assume it to be an infection of the peritoneum due to nervous influences, but where inflammation plays a subordinate part. Others, like Tietze and Lennander, think it to be a benign, serous, or sero-fibrinous inflammation of the peritoneum. The writer asserts that it signifies more; it may mean a slight affection of the peritoneum or it may be the beginning of a very serious peritonitis; for it is met with in all its forms. Lennander advises not to operate in such cases, though Bauer has done so in such cases and found a beginning diffuse peritonitis. The clinical picture is different according to its stage. Easily diagnosed later, at first its recognition is difficult, yet very necessary. The patient is seized by a very violent pain, which may be so great that he may collapse or fall over at once. Colicky pains may precede, though often there are no prodromes. The pain may be in the epigastrium or about the umbilicus, and rarely near the cæcum. There may be vomiting, not rarely loose stools. If one come to examine the patient one or two hours later, it may be that nothing particularly is to be detected, the pain has disappeared or is indefinite, the pulse may be normal, the temperature but little above the normal, or even normal, though it may be high. If one then palpate the patient's abdomen, one will find sensitiveness to pressure over the ileocaecal region, while the patient's abdominal muscles become tense. If one suspect perforative peritonitis, one should examine later, when the signs will be more pronounced. If, then, the symptoms tend to become aggravated progressively, then the process is probably diffuse, rather than localized. The risk is so great that one should not attempt to treat these cases medicinally, unless the services of a good abdominal surgeon cannot be obtained. If there be pronounced peritoneal sepsis of a high grade, one should abstain from operating; yet it must be admitted that surgical measures have rendered the outlook in these cases brighter. The earlier the operation, the better the chances will be; anæsthesia will be better tolerated, only one incision will be necessary, the appendix is free or

but little adherent, the abdominal cavity need not be washed out, but little pus has been formed, and the intestines are not paretic. This holds good if operation be done within the first twenty-four hours; within the next two days there will be a fully developed peritonitis. Of his cases, fourteen operated on within thirty-six hours, all recovered; out of eighteen which came into his hands later, fourteen died. Hence, in diffuse purulent peritonitis, one should attempt to diagnose and operate early in the disease. This requires the co-operation of both physician and surgeon. At the discussion, Dr. Young, of Chicago, stated that in America the practitioners had learned to diagnose early and to call a surgeon within forty-eight hours. If this is impossible, the treatment is: nothing to eat, nothing to drink, that peristalsis allow a local peritonitis develop, which is opened like an abscess.—*Hospitalstidende*, No. 41, 1901.

Frank H. Pritchard, M.D.

COLLARGOLUM IN CASES OF PUERPERAL SEPSIS.—Dr. G. Woyer, of Vienna, is an enthusiastic advocate of inunctions of collargolum, or Crédé's soluble silver, in puerperal sepsis or in any form of general sepsis. Only a fresh preparation should be employed, and should be kept in a cool place, away from chemicals and the light. He has observed such immediate and striking results in serious cases that he cannot help but ascribe the effect to the remedy. He cites three cases, of which the first is a good example:

Mrs. O. S., a primipara, who, after a normal labor with a prolonged first stage, presented an adherent placenta, which was removed manually, followed by irrigation of the uterine cavity with a solution of lysol. Was free from fever for three days, though her pulse was 120. On the fourth day she had a violent chill, and the temperature ran up to 39.8° C. (102° F.), with foul-smelling lochia and tenderness of the uterus to pressure. That day she had three more rigors, and the evening temperature rose to 40° C. (104° F.). The next day he saw the patient in consultation, and diagnosed septic endometritis. The uterus was washed out with a 50 per cent. solution of alcohol. No improvement; milk, stimulants. The sixth day the evening temperature was 40.5° C. (105° F.), the pulse 140 in the minute, small, and there was albumin in the urine. The patient was stupid. Nourishing food and stimulants. This state persisted for two days longer unchanged, the rigors recurring three to four times a day, while she was seemingly becoming worse, more soporous, and nutrition was only possible by rectal feeding; so that the prognosis appeared gloomy enough. Crédé's collargolum was rubbed into the skin of the arms, thorax and thighs, at intervals of ten hours, employing about 3 gms. (grs. xlv) each time. The area to be treated was first carefully disinfected, taking about half an hour to rub each portion in. Though very skeptical of the results, he was greatly astonished, after three inunctions, to see the morning temperature fall to 38.7° C. (102° F.), the pulse improve and the sensorium become brighter. On the following, the eleventh, the temperature was 38° C. (101° F.), pulse 110, the patient bright. During the night she obtained several hours' good sleep. Her abdomen was quite soft, the uterus three finger's-breadth above the symphysis, the lochia purulent, but not fetid. Her temperature and pulse continued to improve, her general condition gradually became better, until, on the twenty-fifth day, she was able to leave the bed. After that she improved rapidly, and wholly recovered. Granting the difficulty of judging the outcome in cases of puerperal

sepsis, in these three cases the turn for the better was so immediate and striking that he can only attribute it to the treatment, for previously everything known to art had been done. Hence, in cases of grave sepsis, particularly the puerperal variety, he warmly advises one to try this method, Cr  d  's silver "Schmierkur."—*Muencheener Medicinische Wochenschrift*, No. 42, 1901.

Frank H. Pritchard, M.D.

CAMPHOR EATERS.—According to the *Hospitalstidende*, No. 40, 1901, there is said to be a widespread habit among the ladies of North America of eating camphor to improve one's complexion. Taken in small doses, it is thought to give one a clear and white tint. Camphor produces, if consumed for some time, a sort of chronic intoxication of an agreeable character, so that breaking off the habit becomes difficult. These subjects have a dreamy and absent-minded look, while the majority have a continual tendency to rest and sleep. Long-continued use brings about a state of general weakness, and at times the symptoms may resemble those of chronic alcoholism.

Frank H. Pritchard, M.D.

THE APPLICATION OF THE FORCEPS IN BREECH POSITIONS.—(Eckstein.)—The writer has treated three cases successfully in this manner, and recommends a more extensive trial of the application of the ordinary obstetrical forceps to those cases of complete breech presentations in which the breech is fixed in the pelvis and delivery is necessary, and in which the fingers cannot be hooked into the groin. Traction should be applied gently, and correspond to the rules for manual extraction. The extraction of the breech with forceps is never necessary. The purpose of the application of the forceps is to make the breech more accessible for manual aid. They are to be applied the same as in head positions, and slipping of them is not to be feared.—*Prager Med. Wochenschrift*, 1901, No. 25.

George R. Southwick, M.D.

EXTERNAL VERSION FOR BREECH CASES NEAR THE END OF PREGNANCY.—(Spencer.)—Wiegand and recently Pinard have recommended external version for the treatment of breech positions. Spencer has tried it six times in the seventh and eighth months respectively, and labor has taken place spontaneously at full term with the head presenting. The breech is raised with one hand and pressed to one side, and with the other hand the child's head is pushed toward the side corresponding to the child's back. If the abdomen is pendulous, a binder must be worn. The version should be performed whenever possible in the seventh or eighth month, as it is more difficult later or impossible at full term. Contra-indications are twins, contracted pelvis, placenta pr  via or a dead child.—*Brit. Med. Journ.*, May 18, 1901.

George R. Southwick, M.D.

THE PATHOLOGY AND TREATMENT OF POSTERIOR PARAMETRITIS.—(Br  se.)—The writer draws the following conclusions:

1. The parametritis of Schultz is a disease of the connective tissue, and not of the peritoneum.
2. The parametritis posterior and the circumscribed parametritis atrophicans (paraproctitis) of Freund are the same processes.
3. Parametritis posterior is often associated with disease of the peritoneum, of the tubes and ovaries, and not infrequently with parametritis atrophicans of other portions of the pelvic connective tissue.

4. Ventral fixation, even in an ante flexion of the uterus, is a most excellent means for the cure of parametritis posterior, which defied all other therapia.

5. Ventral fixation is to be preferred to all other operations for retroflexion for those cases of retroflexion of the uterus which are fixed by parametric processes or are complicated with chronic parametritis.—*Zeitschrift für Geburtshülfe, u. Gynäkologie*, Bd. 46, H. 1, 1901.

George R. Southwick, M.D.

THE INFLUENCE OF PREGNANCY AND THE CLIMACTERIC ON CANCER OF THE UTERUS.—(Kense.)—Cancer of the body of the uterus offers a far better prognosis than cancer of the cervix. The climacteric exercises a restraining effect on the growth of cancer and on its recurrence which is directly contrary to the effect of pregnancy. The better prognosis of cancer of the corpus uteri depends on the influence of the climacteric, as well-preserved and well-developed muscle fibres in the uterus are not found in the climacteric. The radical operation for cancer of the uterus finds its most unfavorable prognosis during pregnancy, labor or puerperium, and its best prognosis during the climacteric.—*Zeitschrift für Geburtshülfe und Gynäkologie*, Bd. 46, H. 1, 1901.

George R. Southwick, M.D.

THE BLOOD IN APPENDICITIS.—From personal observations, Da Costa deduces the following conclusions:

(1.) The average case of appendicitis before operation shows a loss of about 30 per cent. hæmoglobin, and of more than one-half a million red cells per c.c. Occasionally the anæmia is of so high a grade as to cause doubt as to the safety of a surgical operation. Doubts on this score, however, have not been justified by the records of the cases cited.

(2.) Moderate leucocytosis may occur both in the absence and in the presence of an abscess and its consequences. It accompanies about 35 per cent. of the non-purulent and 95 per cent. of the purulent cases.

(3.) Leucocyte counts ranging between 10,000 and 15,000 cannot be depended upon to reflect the nature of the local lesion, since this degree of increase may be found both in mild catarrhal and in purulent cases. Counts of 20,000 or more almost invariably indicate pus, gangrene, or general peritonitis, one or all.

(4.) Leucocytosis may be absent both in trivial catarrhal and in fulminant cases, as well as in forms of circumscribed abscess.

(5.) In operative cases, thorough evacuation of the abscess is followed within a few days by a decline to the normal in the number of leucocytes, providing that the recovery is uneventful. Persistence of a leucocytosis after fourth day may be attributed to undrained pus pockets or general peritonitis.

From these conclusions it is obvious that a daily leucocyte count may serve as a diagnostic and prognostic sign.

The value of the blood count in differential diagnosis is impaired by reason of the conditions so closely resembling appendicitis, as ovarian abscess, pyosalpinx and ectopic pregnancy. In doubtful cases a leucocyte count is sufficient to exclude enteralgia, lead colic, ovarian neuralgia and movable kidney.—*American Journal of the Medical Sciences*, November, 1901.

William F. Baker, A.M., M.D.

SOME NEW POINTS IN RAYNAUD'S DISEASE.—(Beck.)—That the changes in Raynaud's disease are not confined to the soft tissues, but also affect the bones, can be well demonstrated by the Röntgen rays. In the case reported the skiagraph showed atrophy of the upper ends of the third phalanges and osseous proliferation at the upper end of all the second phalanges. There was also thickening of the epiphyseal ends of the second, third and fourth metacarpal bones. The nutrition of the bone is much more disturbed by this unrecognized trophic lesion than is assumed.—*American Journal of the Medical Sciences*, November, 1901.

William F. Baker, A.M., M.D.

SOME NEW POINTS IN TENDON SURGERY.—Coolidge (Chicago) goes over this important branch of surgery from the light of modern ideas. Stress is laid upon the transplantation of a strong, healthy muscle into the tendon of a paralyzed muscle, after the method suggested by Nicoladoni some seventeen years ago. In every case a special study of the muscles involved must be made, and if it is possible to transplant a living tendon to replace the paralyzed one, it should be done. This has been found to help in two ways: first, the direct motion given to the joint; and secondly, quite often the muscles have been paralyzed simply by being overstretched by the strongly contracted opponent, and when this opponent is divided their power is not slow in returning. There are several important points to be considered:

(1) The operation should never be done until the reparative process, which follows an attack of infantile paralysis, has quite reached its limit. At least not before two years after the attack.

(2) Compare the amount of strength of the muscle to be grafted with the work it will be called upon to do, so as to avoid overstretching. Two or more weaker tendons can be used for an important function.

(3) Graft tendons in preference to muscular substance, and, if possible, do the grafting above the annular ligament, so as not to cause displacement.

(4) The method of joining the tendons together. The best plan is to pierce the normal tendon, to pull through the paralyzed tendon, and secure it by sutures. Or, cut the paralyzed tendon quite long, fold it down and suture it to itself, first taking a stitch at the bottom of the slit in the tendon, to prevent its splitting out to the end. Employ a little tension at the time of grafting.

(5) Silk or catgut is used for the suture. Silk occasionally causes trouble some time subsequent to the operation. If catgut is selected, use the chromicized gut, with a life of from four to six weeks. Silver wire should be kept in mind.

(6) The post-operative treatment is of importance. Keep the limb in the corrected position in a plaster-of-Paris bandage for four weeks, then use massage and passive motion, and some retention appliance for two months more.

The author points to the well-known fact that tenotomy of the affected muscles in cerebral spastic paralysis causes the spasm to disappear. He makes a plea for the more extended use of this procedure in this disorder, and claims that it is applicable to any muscle so affected. If there is fear that the cut tendon will not unite (those that run in sheaths tend to non-union after tenotomy), then tendon lengthening should be practiced. Two cases are reported where this was performed on the quadriceps extensor ten-

dons with excellent results, the patients both becoming able to walk, whereas they were bedridden and helpless before the operation. The method used was that of Anderson.—*Annals of Surgery*, May, 1901.

Gustave A. Van Lennep, M.D.

COLOSTOMY FOR CHRONIC DYSENTERY.—Murray (New York) suggests the formation of an artificial anus in those cases of chronic dysentery that have not been cured or ameliorated by medical treatment in four months' time. He points to the fact that the conditions which are requisite for success in the treatment of this disease are cleanliness and an enforced rest of the ulcerated tissue. Cleanliness may be accomplished by means of irrigation of the rectum and colon, but only a limited portion of the lower bowel can be reached ordinarily, and consequently the ulcerative process in the transverse and ascending colon is inaccessible and uninfluenced by the injection. He recommends, therefore, that by forming a complete artificial anus, preferably on the right side, we can put the colon at rest, and through the bowel-opening we can, in addition, carry on a thorough and satisfactory local treatment of the colonic ulceration. The artificial anus should be left open for a long time, several months, perhaps, and its subsequent closure should not follow until it is quite certain that the ulceration is healed. To ascertain this fact we can, by means of the long rectal tube of Kelly, inspect the rectum, the lower sigmoid, and, by introducing the tube through the wound into the ascending colon, we can make sure of this portion up to the hepatic flexure. When these portions of the colon are found free from ulceration, and the examination of the irrigations for several weeks are negative as regards the presence of the amœbæ, then we can restore the continuity of the gut.

Should the mesentery of the colon be too short to allow of the formation of a complete artificial anus, or if it is evident that the ascending colon is ulcerated, then we may proceed higher up and perform the operation on the ilium. Ileostomy would serve as well, and the subsequent closure would be easier and less dangerous. This method of treating amœbic dysentery, when performed at an early date, and after the failure of medical measures, and when followed up by a persevering and thorough local treatment of the ulcers of the colon, holds out a good prospect of cure, and, in view of the present want of success of medical treatment, is worthy of trial. The author reports one case in which the procedure was tried. An incomplete right inguinal colostomy was done, and persistent irrigation of the ascending, transverse and descending colons with various solutions kept up for three months or more, with marked benefit. Nitrate of silver, 1 to 500 or 1 to 250, appeared to work the best. The stools were finally cut down to three a day, but mucus was always present. The patient gained in weight and strength, and was able to work at his trade. The colostomy wound had practically healed in six months. The author believes that if a complete colostomy (which the patient refused) had been done a cure would have resulted. This proves to his mind that irrigation by itself is not sufficient to a cure, but must be combined by absolute rest of the mucous membrane, only brought about by completely shutting off the faecal circulation and placing the colon at rest.—*Annals of Surgery*, May, 1901.

Gustave A. Van Lennep, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY O. S. HAINES, M.D.,
with the collaboration in German literature of C. Sigmund Raue, M.D.

THE FULGURATING PAINS OF LOCOMOTOR ATAXIA.—Dr. F. Cartier says that in three cases of locomotor ataxia he was able to cure the fulgurating pains with *kalmia latifolia*. Its action was prompt and decisive. (We can report great benefit from the administration of the same remedy in an obstinate case of right-sided facial neuralgia. It was selected according to the usual method, of comparing symptoms and modalities with the pathogenesis; and, although section of the nerve had failed, *kalmia* ameliorated the pains to such a degree that the patient was satisfied, and always keeps it by him to prevent a return of the suffering.)

ADONIS VERNALIS.—Dr. M. H. Chamberlain, of Monrovia, Cal., says that for some time he has been looking about for a remedy which he could use in cases of very low vitality, with weak hearts and slow, weak pulses. He thinks he has found the remedy in adonis. High dilutions of digitalis have disappointed him, and he has been afraid to use digitalis in tincture in these cases "for fear of breaking still further the low vitality left in the heart." He also dislikes to use strychnia, because he has found it to be too irritating to the nervous systems of these patients. His experience with adonis proves it to be a safe and valuable remedy. Five or ten drops of either the tincture or the first decimal dilution are put into a half-glass of water, and teaspoonful doses administered every hour or two. It has improved the strength and rapidity of the pulse in a few hours. It seems to act best in cases in which there is little blood in the arterial system, but too much and too high a pressure in the venous system. So the author uses it in very weak heart with valvular troubles, and "where the richness of the blood has been destroyed or deteriorated by septic or toxic conditions, as in Bright's disease, with dropsical swelling and scanty and albuminous urine; or after diphtheria, where the pulse was slow and weak, being only 50 or 60 per minute."—*Pacific Coast Journal of Hom.*, November, 1901.

THE ANTHELMINTIC TREATMENT OF APPENDICITIS.—Worms seem to exert both a direct and indirect action upon the vermiform appendix (perhaps isopathically), in the belief of Dr. Metchnikoff. To begin at the tail end of a story, he says: In all cases with signs of appendicitis we should proceed to make a helminthological examination of the fæces. Whenever possible, proceed with an anthelmintic treatment, using santonin for ascarides and thymol for tape-worms. Furthermore, patients prone to appendicitis should avoid

raw vegetables, strawberries, etc., and drink boiled water. This regimen offers a splendid prophylactic for appendicitis.

He also recommends that from time to time the fæces of children be examined microscopically. Many a worm would thus be anticipated in his turning up, and we could keep ourselves busy and incidentally run up a bill.

A case is cited of a man, æt. 23, suffering from recurring appendicitis. There was intense colicky pain without diarrhœa; vomiting; tenderness at the McBurney point, and a doughy tumefaction in the right iliac fossa. A microscopical examination of the fæces revealed eggs of the trichonocephalus and ascarides. Santonin and calomel was given, and a speedy recovery followed. The question is, Which gets the decision, santonin or calomel?—*Allg. Hom. Zeitung*, September, 1901.

THE SYMPTOMATOLOGY OF COCAINE.—Dr. A. Pfander, of Bern (*Zeitschr. des Berliner Vereines Hom. Aerzte*, October, 1901), has collected an exhaustive symptomatology of cocaine containing the provings of erythroxylin coca and the symptoms observed in acute and chronic cases of poisoning with cocaine. A few clinical reports are also mentioned. The following symptoms, giving promise of practical applicability and usefulness in a variety of conditions, are gleaned from Dr. Pfander's "Symptoman-Verzeichniss."

Mind.—Nervous excitability with weakened memory and capability for mental work. Hallucinations of hearing and sight (sees small objects and animals). Melancholia; delusions of persecution; suicidal tendency; jealousy.

Nervous System.—Trembling of hands; staggering gait. Choreiform jerking of the muscles. Neuralgias and paræsthesia (cellular infiltration and hyaline degeneration of the walls of the blood-vessels in the spinal cord).

Sleep.—Insomnia; late in falling asleep. Great restlessness.

Fever.—Chilliness, increasing to chills. Paleness, with chilliness of entire body; rapid, weak pulse and slight fever.

Skin.—Paleness. Formication. Scarlatinal exanthema, mainly at back of neck. Rupia.

Head.—Vertigo. Headache, mainly frontal. Throbbing and bursting sensation. Supra-orbital neuralgia. Dull, throbbing pain in forehead, left side, with peri-orbital neuralgia. (These symptoms can be relieved by small doses of cocaine, especially if they are periodical in nature.—C. S. R.)

Eyes.—Flickering before eyes. Pupils dilated. Strabismus; nystagmus; amaurosis.

Ears.—Hallucinations of sound.

Stomach.—Anorexia. After complete loss of appetite often canine hunger (chronic poisoning). Nausea; retching and vomiting. Cramp of stomach, often persisting for days.

Abdomen.—Violent abdominal pains (after very large doses). Atrophy of the hepatic cells (observed in days after chronic poisoning, by Zaucher-sky.)

Respiratory Tract.—Difficult breathing. Irregular, periodic breathing. Cheyne-Stokes breathing. Dyspnoea. Sensation as if chest were constricted (persisting until third day after poisoning). Pain in region of upper chest.

Circulatory System.—Spasm of blood-vessels. Palpitation of heart and

præcordial anguish. Extreme cardiac weakness. Syncope. Intermitting apex beat. (I have observed typical angina pectoris induced by cocaine.—C. S. R.)

Clinical.—In a case of cardiac weakness following faucial diphtheria, with small, rapid pulse, Goodno (*California Homœopath*, March, 1901) obtained good results from cocaine, first decimal trit., one grain every two to three hours.

Hale recommended it for cardiac exhaustion following overexertion, such as heavy lifting or mountain-climbing. (This is simply borrowed from the empirical use made of coca leaves by the natives of South America.)

Dr. R. T. Cooper (*The Clinique*, December, 1898) relieved the "sensation of foreign bodies under the skin," in a case of chronic rheumatism, with small doses of cocaine.

Dr. Pfander is of the opinion that cocaine may be of service in heart affections. In melancholia and folie circulaire it may also be of use. While it seems capable of producing symptoms closely resembling progressive paralysis, still he feels that it can be of no benefit here.

In delirium tremens it may prove of value. He suggests that it be tried in chorea and epilepsy. Also in neurasthenia and insomnia.

The throat symptoms closely resemble belladonna, and it may prove curative in angina accompanied by a feeling of constriction of the throat with great dryness.

Toxicologically, it seems most nearly related to atropin.

THE TREATMENT OF ŒDEMA.—The late Carroll Dunham said: "The practitioner of medicine, in the exercise of his profession, performs many functions." Then he went on to show how it was impracticable for the practitioner always to act toward his patients in the capacity of *homœopathic* therapist. When called upon to take charge of a sick person, the first business of the practitioner is to find out what ails the sufferer. Then follows the recognition of the therapeutic requirements of that case. To offer a drug to a case that urgently demands surgical interference is as bad as it would be to offer a homœopathically selected remedy to another case which demanded tapping and the administration of a diuretic and a purgative for the *relief* of an extensive dropsy, dependent upon a mechanical obstruction which was incurable. The majority of homœopaths have grown wise enough to recognize the truth of this. Carroll Dunham was one of the most conscientious homœopaths that ever lived, but he recognized the limitations marking the sphere of the similimum, and he did not attempt impossibilities. We think that it must have been with some such thoughts as these in his mind that Dr. George F. Laidlaw set about writing his article upon "The Treatment of Œdema." He takes as his text the case of an elderly man whom he once treated for general dropsy. This man had a badly-damaged heart, a mitral lesion with hypertrophy, his urine was scanty and albuminous. He was water-logged, and could not lie down. He had taken a lot of medicines, but had not been relieved by them. Dr. Laidlaw began by recognizing the therapeutic needs of the case. He tapped the abdomen and withdrew six quarts of serous fluid, which procedure, of course, very quickly helped the dyspnoea and abdominal distress. Then he gave the man Dr. Laidlaw's favorite diuretic—the borotartrate of potash. It failed to act, which simply

shows that it is not always safe to back a favorite. Then the doctor prescribed a compound diuretic which he had learned from Dr. Macy, of New York. This consisted of the tinctures of *apis-apocynum-helleborus*, mixed in equal proportions. Ten drops of this mixture were dissolved in four ounces of water and one teaspoonful given every hour or two. The effect of this diuretic was prompt and satisfactory; for several days thereafter the patient passed more than a gallon of urine per diem. The œdematous tissues shrunk in the customary manner, the transudates were absorbed from the cavities, albumin disappeared from the urine, and the patient was able to be about as a comfortable invalid. (This experience interested us, so that we gave this mixture, as directed by the author, to a similar case of our own; it certainly acted promptly, increasing the urine from twenty ounces to sixty ounces within two days.) Dr. Laidlaw makes this case a text for some observations upon the treatment of non-inflammatory œdemas and serous effusions.

Diuretics palliate; they do not cure. It is possible, however, that after the diuretic relief of an œdema, the *vis medicatrix nature* may be sufficient to bring the patient's tissues back to normal; or it is very probable that the similimum will then act to better purpose. Generally the œdema will return, showing that the real disease is only lying latent, and that it has not been really cured. The treatment of this underlying disorder is the sphere of the homœopathic remedy, which should be prescribed in close accordance with the symptomatology.

Now, it appears to us that frequently, if not very generally, the disease of which the œdema is only the prominent symptomatic feature is an incurable one. The best that one can do, under such circumstances, is to mitigate the symptoms without curing the patient. We should like to know which plan of treatment makes quicker for the accomplishment of this result: the use of the physiologically acting diuretics and purgatives, etc., or the simple administration of the homœopathic similimum. We take it that Dr. Laidlaw has little confidence in the power of the homœopathically chosen remedy to relieve promptly an œdema or an anasarca that is dependent upon mechanical causes. But it will do this occasionally. We have seen a few cases of general dropsy, dependent upon serious organic changes in the heart and kidneys, that have yielded as promptly and satisfactorily to the similimum as could have been desired. The temptation has been great to publish these results, but it would have been misleading, for we have likewise seen scores of such cases, in which the administration of what was supposed to be the similimum was followed by absolutely no appreciable good effects. Now, the whole truth of the matter is that, when one is called to treat a case of this kind, he cannot tell beforehand which remedy is going to help. Indeed, he cannot say that any remedy will help. He simply has to try things on his patient. If he is a strict Hahnemannian prescriber, he tries a great many similar remedies in a great many different potencies, selecting these sometimes upon one symptom and sometimes upon more than one symptom. If he is not so straitlaced in his theoretics, he gives one or two remedies upon symptomatic indications, and, when these have failed to act, he tries various physiological diuretics and purgatives. But it is uncertainty and doubt. Why, you can hardly name a diuretic that will act favorably on two cases in succession.

We may as well stand right up to these facts and look them squarely in the face. Dr. Laidlaw says: "It is a maxim with me that the appropriate diuretic works quickly; if within twenty-four or forty-eight hours the urine shows no increase, it is better to change the diuretic." The author, recognizing the uncertainty of drug action in these conditions, seeks to explain the reason why we cannot tell beforehand whether one remedy will or will not relieve the dropsy. If the kidneys were simply a pair of faucets which required to be turned on, the treatment of these dropsies would be a simple matter; but when our understanding of œdema comprises a disordered kidney function, a disordered function in the œdematous tissues and a disordered condition of the blood, we can understand that for a diuretic to be effective it must meet all these conditions. As the elements of renal insufficiency, lymphatic disorder and blood quality are seldom active in the same proportion in any two cases, we can understand why a diuretic which is strikingly curative in one case is totally inactive in another. Whether this explains it or not, the fact remains. With our imperfect indications for one diuretic or another, we fail to make that accurate adjustment of drug to disease which is so essential. Just here, says the author, homœopathy should come in to help us, with its delicate adjustment of drugs to conditions. Well, it is a question whether, as a rule, the *similimum* may be depended upon to the extent of always removing the extensive dropsies which are the result of mechanical obstructions and pressure. Most of us are glad, in the majority of instances, that we can resort to diuretics, the trocar, purgatives and the other mechanical agents, which are a part of the palliative armamentarium of all schools of medicine.

Dr. Laidlaw refers to his favorite diuretic, the soluble cream of tartar—a level teaspoonful, given in one-half glass of water every three hours, until a slightly laxative effect is produced. Then the dose is regulated so as to secure about two loose passages each day.

He also mentions the distilled quassia water, in the ascites and œdema of chronic liver disease, and the acorn water, which cures dropsy dependent upon disease of the spleen. He gives the formulas for the preparation of these diuretics. Altogether the article bears the impress of a straightforward, honest man.—*N. A. Journal of Homœopathy*, November, 1901.

GYNÆCO-THERAPEUTICS.—In the November number of the *Monthly Homœopathic Review* may be found a very interesting paper upon this subject, written by Alfred E. Hawkes, M.D. Dr. Hawkes remarks, in opening his article, that of late so much has been relegated to the surgeon, in this department of our calling, that one might, in all sincerity, question whether anything remained for medicine to do. Diseases of the female genitalia, like appendicitis, brain lesions and pleurisy, demand that they shall be treated only by those whose faith in physic has not rendered nugatory their surgical education. We do not think that any general practitioner is ever justified in treating a pyosalpinx by remedies, rest, douching, etc., unless he does so under the watchful eye of a surgical consultant. The author has seen more fatal cases from ruptured pyosalpinx than from appendicitis. He has apparently searched very thoroughly the repertories and materia medicas for either symptomatic or pathological references to the ovarian tubes. In the "Cyclopædia of Drug Pathogenesis," reference to the tubes is found only

under arsenicum and merc. cor., and these are postmortem findings. In the "Cypher Repertory," however, we find "burning in the right ovary" under eupion. Dr. Hawkes has long associated the term "burning," so often used by patients, with tubal diseases. Allen adds another symptom, "gushing leucorrhœa," to the pathogenetic effects of eupion. Dr. Hawkes says "there is no remedy that I use so often in chronic tubal disease, nor is there one with which I am so well pleased." (In the distillation of wood-tar, the volatile oil separates into a heavier oil, kreasote, and a lighter oil, which is the eupion referred to.)

Apis.—While the provings do not probably bring out clearly the wonderful effects of this remedy upon the ovaries, yet the clinical experiences of many physicians amply confirm these. The author refers to three cases in which tender enlarged ovaries could be palpated; under apis 3 the most signal benefit accrued.

Bryonia.—The symptom, "in the region of the right ovary, severe pain, as if the part was torn or wrenched, extending to the thigh," is probably very reliable.

Lilium Tigrinum.—One may find in the *Cyclopædia* the details of undoubted cases of *anteversion* produced by this drug. Dr. Hawkes has much confidence in this drug. The symptoms which are most helpful will likely be these: "Tenderness when pressure is applied to the ovarian region, aching and burning like coals of fire, burning across the hypogastrium, extension of the pains down the thigh (think also of bryonia and crocus), pain in sacral region (berberis), prolapsus with dragging pains (sepia and helonias), aggravation at night and diarrhœa in the morning, despondency and mental depression."

In the ovarian symptoms of *hysteria*, zincum val. has been found of great use.

In the treatment of the endometritis associated with fibroids, the author is uncertain as to the value of curettement. He, however, has found that crocus is the best hæmostatic, when hæmorrhage is the troublesome symptom, and this observation is indeed a valuable one. He does not place much dependence apparently upon the crocus symptom of "feeling as if something were moving in her inside." He has, however, cured with hyoseyamus when this symptom was prominent.

When speaking of the action of various drugs upon the uterus, Dr. Hawkes arranges the dependable remedies for *leucorrhœa* in this way: Leucorrhœal discharge from *body* of uterus: Aurum, chinin., copaiba, ferrum, fer. iod., lilium, magnesia, mercury, murex, sabina and silicea. Leucorrhœal discharge from *cervix* of uterus: Ammon. muriaticum, arsenicum, bovista, kali bichromicum, mezereum.

Aurum muriaticum has been used a great deal in indurated conditions of the uterus, but it would be hard to give a better description of certain forms of obstinate *vulvitis* than the following: Redness and swelling of the vulva, continual oozing at vulva, yellow and clear leucorrhœa, acrid leucorrhœa, making the thighs sore; itching of the genitals.

Copaiba has prominently pressure upon the uterus, with milky, acrid leucorrhœa, excoriating the vulva. Feeling as if prolapsus would occur.

Ferrum iodatum acts especially upon the cervix uteri, and is indicated very often in cases presenting the symptom *stringy, starchy* leucorrhœa.

Lilium tig.—To what has already been said about this remedy we may add, acrid, brown staining leucorrhœa, as well as the light yellow flow.

Murex.—Dr. Hawkes has an increasing regard for this drug. The symptom, an existing leucorrhœa becomes *sanguineous*, gives a clear view of its pathogenetic tendencies.

Silicea.—We think that the following observations upon this remedy will be of use. Silicea is useful, in the usual dilutions, in that form of leucorrhœa met with in women long past the menopause. It is characterized by a thin, watery, irritating discharge. Dr. Hawkes mentions the cases of two old ladies who, being much inconvenienced by such a discharge, were favorably influenced only by silicea.

Kali bich.—Yellow, tenacious leucorrhœa, with concomitant pain and weakness across the small of the back, and dull, heavy pains in the hypogastrium.

Hydrocotyle.—Dr. Hawkes has long used this remedy for the *pains of cervical cancer*. He was thus enabled often to withhold the morphia sulph.

Referring to the treatment of urethral caruncle, the author says that he has never been able to influence the condition accompanying this local affection, much less remove such a growth by an internal remedy. He mentions a condition of the meatus which might be described as ectropion. This eversion of the lower portion of the urethra, and the superadded irritation around the meatus, has yielded to capsicum and the local application of calendulated boric acid.

Speaking of the frequency with which the practitioner is called upon to treat *dysuria*, Dr. Hawkes refers to a number of useful remedies, thus:

Apis mellifica.—While, perhaps, burning in the urethra before and after urination is more characteristic of the apis, yet it is also very useful for that form of spasm of the bladder which is so well indicated by the symptom of *ruta graveolens* which reads: "Pressure in region of the neck of the bladder, like a painful closure of it, shortly after urinating." *Ruta* is curative in such a case, and so is apis.

AN INVOLUNTARY PROVING OF ANTIMONY.—Dr. Frederick B. Percy has communicated to the profession the details of an involuntary proving which was made by a friend of his, engaged in the manufacture of the double lactate of antimony and soda. This salt is used by the dyers. In the comparison of the symptoms produced with the generally accepted symptoms of antimony crudum, a remarkable confirmation of the latter will be noticed. First was observed a decided lowering of the general health; then followed great sensitiveness to cold; he was only comfortable in a room of 80 or 85 degrees. He was obliged, therefore, to give up cold baths to which he was regularly accustomed. He had a nasty, coated tongue. Great digestive disturbance, much gas in the intestines. Watery and mucous discharges from the intestines. His heart, which had always been quick and strong, became most erratic, jumping from 56 to 150 per minute, from strong to quick, and *vice versa*. He became extremely melancholic. Watery pustules appeared upon the wrists and arms, resembling, to him, ivy poisoning. The inflamed parts itched intensely.—*New Eng. Med. Gazette*.

DIABETES AND THE ADDICTION TO SWEETS.—In a very readable article (*N. A. Jour. of Hom.* for Dec.) Dr. Clifford Mitchell reiterates his previ-

ously expressed belief that in diet and regimen lies our chief hope of holding the disease or deterioration in check. He divides his cases into two groups, the *manageable* cases, and the *unmanageable* ones. This division is accomplished by the use of the ferric chlorid test. Excluding the presence of drugs, any urine which gives a wine-red color with a few drops of a 20 per cent. solution of ferric chlorid, indicates that the case passing it is an *unmanageable* one. If the Haines' test shows the presence of glucose, and the ferric chlorid reaction is absent, that case may be regarded as a more or less manageable one, regardless of the *amount* of the sugar and the symptoms present. But whether the case will prove to be more manageable or less so, depends upon the *addiction of that patient to sweets*. From what Dr. Mitchell says, it would appear that we doctors, in treating diabetics, have to deal not merely with a disease, but with an addiction as well, and that our success will depend upon how well we manage this addiction. The author treats the addiction by alarming the patient to the limit; that is, to as great an extent as possible, without bringing on a nervous terror. Then he places his patient on a diet of meats, eggs, and nitrogenous green vegetables for a few weeks, until the sugar has been reduced to 1 per cent. or better. Then the patient may eat anything which fails to increase the amount of sugar in the urine, *always excepting sweets*. Hot, alkaline, laxative mineral waters are of great value, if taken before meals. Exercise in the fresh air and trips are of assistance. Dr. Mitchell prefers, as a medicine, small doses of arsenic.

FERRUM PHOS.—PNEUMONIA.—Dr. Joseph C. Guernsey thinks that the symptom "expectoration of *pure blood*" is one of the most dependable indications for ferrum phos. in pneumonia. He also believes that this remedy should not be classed with aconite, as a remedy suitable *only* for the initial and early stages, because ferrum phos. will often be of great service even in the more advanced stages of the disease. We heartily endorse these statements.

A POINTER FOR THE SURGEONS.—Dr. Samuel Parker Hedges, in his recent article upon "Injuries to the Genital Tract," has something to say about the advantages to be derived from the post-operative administration of the homœopathic remedy. The tendency in the surgical mind to-day is to ignore internal medicine. Their whole thought is to rely upon Nature alone, or assisted by local measures and the usual opiate. Dr. Hedges thinks that the surgeon's cures would be much more complete under the benign influence of the indicated remedy. There are, at the present, two distinct divisions in our ranks in regard to the treatment of diseases of women. One does nothing but operate and give local treatment; never prescribes a remedy—may order a cathartic or opiate or tonic. The other division does nothing but give the indicated remedy—absolutely nothing else, except to caution as to diet. Both of these classes are wrong. A happy medium, as usual, is better. Dr. Hedges calls the attention of our surgeons to the advantage of the more constant prescribing of the *homœopathic remedy* in post-operative treatment, and we concur in all he says. The fact that a patient required an operation is conclusive evidence that she also needs internal remedies to aid Nature in overcoming the predisposing causes which have led to the diseased conditions requiring the operation.—*Hom. Jour. of Obstetrics*.

THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER.

A Medical Newspaper.

EDITED BY

HERBERT P. LEOPOLD, M.D.

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A Text-Book of the Practice of Medicine. By A. C. Cowperthwaite, M.D., Ph.D., LL.D., Professor of Materia Medica and Therapeutics in the Chicago Homœopathic Medical College; formerly Professor of Materia Medica and Therapeutics in the Homœopathic Medical Department of the State Universities of Iowa and Michigan; Ex-President of the American Institute of Homœopathy, etc. Including a section on Diseases of the Nervous System, by N. B. Delamater, A.M., M.D., Professor of Mental and Nervous Diseases in the Chicago Homœopathic Medical College, Chicago. Halsey Bros. Co. 1901.

Dr. Cowperthwaite is so well known by his favorable work in the past that he requires no introduction to our readers. This, his latest addition to the realm of medical literature, will add to his already well-earned laurels. When a work on practice presents so many points of excellence, it is difficult to single out any one for mention. The symptomatic pictures of disease are correct

throughout, and the data upon which the reader is instructed to make his differentiation are clearly stated.

Quite naturally, it is to the therapeutic portion of the work to which one directs his attention, as treatment, after all, is the ultimate object of medicine. The directions given by the author are those derived from an extended experience of over thirty years. An innovation of which the author expresses his disapproval, but which we—and we believe his readers, also—cannot but commend, is specific statements as to the preparation and strength of the various medicines as he employs them in the diseases in which they are indicated.

Of Dr. Delamater's portion of the work we also take pleasure in speaking in terms of praise.

The mechanical execution is above criticism. Indeed, it is a fine example of the printer's art.

We cannot avoid criticising certain of the author's therapeutic suggestions as to the management of syphilis. He quotes from Goodno's "Practice" to the effect that in nervous and visceral syphilis the dose of iodide of potassium required is limited by the patient's tolerance. He then goes on to say: "I have no sympathy with such statements, especially when coming from homœopathic sources." On page 756, speaking of the prognosis of cerebral syphilis, he says: "The prognosis is usually regarded as favorable. Such, however, has not been my experience." Turning to page 763, we find the late Dr. Trites, and Dr. Carleton, of New York, quoted approvingly. Inasmuch as the reviewer was the author of the article on "Syphilis" in Goodno's "Practice," and it is so stated in the index of that work, he cannot refrain from criticising Dr. Cowperthwaite's reference. In the first place, we would say that, if the author will but use the iodide of potassium as recommended in Goodno's "Practice," he will not say that the prognosis of brain syphilis is unfavorable. Under its beneficent administration he will see serious symptoms disappear with as beautiful regularity, almost, as ice under an August sun. As to Trites and Carleton, who are utilized as authority for the value of iodide of potassium in doses not specified, we acknowledge that we received our first lesson in the administration of massive doses of potassium iodide in tertiary syphilis from Dr. Trites; and we happen to know that Dr. Carleton agrees with us, that there are cases in which their administration is absolutely necessary.

But our author does not have any sympathy with such statements coming from homœopathic sources. Yet we find him, in another portion of the book recommending cardiac tonics, exhibiting remarkably good knowledge of the indications for their use on physiological principles. What is more astonishing, he uses some of them in doses which are sufficiently large to pass the point of tolerance of some individuals. Perhaps we are wrong, as we have never used such large doses; but we are willing to live and learn. We shall adopt the recommendations, and hope we may obtain better results than in the past. But these are not the only therapeutic directions in which the author departs from what the purists call homœopathy. Now, we do not wish to be understood as criticising Dr. Cowperthwaite for introducing these measures to his readers. On the contrary, we commend him for his candor. But his hit at iodide of potassium in syphilis impels us to direct attention to such apparent inconsistencies.

Practical Medicine. By F. Mortimer Lawrence, A. M., M. D., Assistant in Practice of Medicine, Hahnemann Medical College of Philadelphia; Chief of Medical Clinic, Hahnemann Hospital Dispensary, Philadelphia. Philadelphia: Boericke & Tafel. 1901. Price, \$3.00; by mail, \$3.25.

The author's preface starts out with : "This book is intended for students, not advanced workers." In other words, it was prepared with the idea of presenting the medical student with short clinical pictures of the various diseases. It is from this standpoint that it must be criticised. A careful review of the text tells us that the author has set forth the fundamental phenomena of disease with clearness and good judgment. This statement carries with it high commendation, as it is well known that it requires more skill to write a small book than a large one, for it is a matter of nice judgment to know exactly what points to omit. We are pleased that Dr. Lawrence has seen fit to precede each chapter with some remarks on "general considerations." Those relating to the infectious diseases are worthy of especial note. On page 20 we find a table giving the periods of incubation and infectiousness of the various infectious diseases, and containing data not, so far as we are aware, contained in any other text-book on medicine.

In giving the differential diagnosis of acute miliary tuberculosis and typhoid fever, we note that no mention of the comparative pulse-rates in the two diseases is made, and yet we regard this as a matter of the highest importance. In acute tuberculosis one finds the pulse disproportionately rapid to the height of the fever, while the reverse obtains in typhoid. We also think that the statement as to the presence of tubercles in the choroid is valueless for all practical purposes, although this symptom is generally mentioned in almost all text-books as of the highest importance. Their presence, of course, argues for much; their absence must be regarded as negative evidence. In doubtful cases, after all, we are compelled to fall back upon the Widal reaction as the one unfailing sign.

Throughout the work we find much to praise, nothing to condemn, and but little to criticise. The concise descriptions of the more important laboratory methods will be found especially valuable.

While Lawrence's "Practical Medicine" was prepared with the needs of the busy medical student in mind, we believe that it will be found useful by the equally busy general practitioner who desires to peruse a short description of a disease with which he may be personally unfamiliar, but has not the time to con over the lengthy descriptions found in the various medical systems and encyclopædias.

American Edition of Nothnagel's Encyclopædia.—Typhoid and Typhus Fevers. By Dr. H. Curschmann, of Leipzig. Edited, with additions, by William Osler, M.D., Professor of the Principles and Practice of Medicine, Johns Hopkins University. Handsome octavo of 646 pages, illustrated, including a number of valuable temperature charts and two full-page colored plates. Philadelphia and London: W. B. Saunders & Co. 1901. Cloth, \$5.00 net; Sheep or half-Morocco, \$6.00 net.

The great repute attained by Nothnagel's Encyclopædia in Germany, where it is the leading authority on the subjects of which it treats, has caused many whose linguistic abilities are limited to English to long for a translation. And now volume I. is before us. As valuable as is the German edition, the American should even be more so, for, besides containing all the material of the original, we have the extensive additions made by that master in clinical medicine, Dr. Wm. Osler.

While, in the greater portion of the book, the translation has been well done, there nevertheless remain portions in which the heavy, lumbering style peculiar to the German is preserved. This applies especially to sections and paragraphs relating to discussions. Where the subject-matter relates strictly to description of clinical phenomena or of facts, the verbiage is above criticism.

The chapter on Bacteriology has been thoroughly revised, and much new ma-

terial added, giving prominent consideration to the distribution of the typhoid bacilli, especially in the urine, the rose-spots, and the blood.

To the chapter on Pathology many minor additions have been made, incorporating the important work of Mallory. The literature on the localized lesions due to the bacillus has been carefully reviewed and made to conform to the most recent advances in that part of the subject. Thayer's exhaustive study of the state of the blood has been utilized, and the Surgical Aspects of Typhoid Fever have been fully revised with the aid of Keen's monograph.

Much valuable material has been added to the chapter on Diagnosis by Bacteriologic Methods, particularly with reference to the recent work in blood-cultures and on the detection of bacilli in the urine.

The chapter on Perforation and Peritonitis has been practically rewritten, as has also the section on the Hepatic Complications of Typhoid.

Thus it will be seen that the American edition of this valuable work, while still possessing all the commendable qualities of the original German, is greatly enhanced in its field of usefulness by being brought strictly abreast of the latest literature on the subjects, and by representative specialists.

A System of Physiologic Therapeutics. A Practical Exposition of the Methods other than Drug-giving in the Prevention of Disease and in the Treatment of the Sick. Edited by Solomon Solis Cohen, A.M., M.D., Professor of Medicine and Therapeutics in the Philadelphia Polyclinic; Lecturer on Clinical Medicine in the Jefferson Medical College, etc. Volumes III. and IV. Climatology; Mineral Springs; Health Resorts. By F. Parkes Weber, M.A., M.D., F.R.C.P. (Lond.), Physician to the German Hospital, Dalston, etc., with the Collaboration for America of Guy Hinsdale, A.M., M.D., Secretary of the American Climatological Association, etc. In two books. Book I. Principles of Climatotherapy; Ocean Voyages; Mediterranean, European and British Health Resorts. Book II. Health Resorts of Africa, Asia, Australasia and America; Special Therapeutics. Illustrated with Maps. Philadelphia: P. Blakiston, Son & Co. 1901.

These two volumes include what is undoubtedly the most complete, and at the same time most valuable, disquisition in the English language on climato-therapy and the health resorts of the world. For practical purposes, it may be divided into two portions, one to be read and kept ever in mind; the other to be used only for reference as circumstances demand. The first portion includes the chapters relating to the elements of climate and its relation to the atmosphere, altitude and aerial currents, soil and general topography, and the classification of climates and general effects of the different kinds of climate. Under this heading also are to be included the closing chapters of Vol. IV., devoted to the general management of patients at health resorts, and the special therapeutics of climate, in which reference to the special management of many local and general diseases is made. The other portion of the work may be described as a dictionary of health resorts, in which every one of those places, the world over, is carefully and accurately described. Of great value is the article on the Hawaiian Islands by Dr. Titus Monson Coan, of New York.

A Text-Book of Medicine for Students and Practitioners. By Adolf Strumpell, Professor and Director of the Medical Clinique at the University of Erlangen. Third American edition. Translated by permission from the thirteenth German edition by Herman F. Vickery, A.B., M.D., Instructor in Clinical Medicine, Harvard University, and Philip Coombs Knapp, A.M., M.D., Clinical Instructor Diseases of the Nervous System, Harvard University, etc. With editorial notes by Frederick C. Shattuck, A.M., M.D., Jackson Professor of Clinical Medicine, Harvard University, etc. With one

hundred and eighty-five illustrations in the text, and one plate. New York : D. Appleton & Co. 1901. Price, cloth, \$6.00.

Strumpell's Practice of Medicine is to the German physician what Osler's Practice is to his American and English colleagues. The importance of new editions in English is therefore evident, if one would keep abreast of advanced medical thought in Germany. The distinguished author expresses in his Preface his wish not to collect all the facts in pathology which have been discovered up to date, nor all the methods of treatment which have been recommended, nor all the theories or views which have been propounded. On the contrary, his wish was to give a complete presentation of the essentials of our present knowledge and views with regard to the different diseases from a scientific and individual standpoint. To this end he has brought the facts of clinical experience into the closest possible relation with the data of pathological anatomy and general pathology, and to deduce from the nature of the symptom a basis for rational medical opinion and treatment, although he has not underestimated the value of simple experience. Since the appearance of the second American edition in 1893, no less than seven new editions have appeared in Germany. The translators have kept as close to the original as seemed consistent with clearness.

The Physicians' Visiting List (P. Blakiston's Son & Co.) for 1902.

The fifty-first year of its publication. It is arranged to accommodate a practice of 25 to 100 patients per day or week. Leather cover, pocket and pencil. \$1.00 to \$2.25.

The worth of this little book has been recognized for half a century, for its neatness, completeness, and simplicity of arrangement. Very few publications of its kind are granted such length of days. It provides blank leaves for Visiting List, Memoranda, Addresses of Patients and Nurses, Obstetric and Vaccination Engagements, Records of Births and Deaths, and Cash Accounts, together with complete table for calculating the period of Utero-gestation, French and Metric dose-tables and systems of weights and measures. It should be in the possession of every careful physician.

Water and Water Supplies. By John C. Thresh, D.Sc. (London), M.D. (Victoria), D.P.H. (Cambridge); Honorary Diplomate in Public Health, Royal College of Physicians and Surgeons, Ireland; Medical Officer of Health to the Essex County Council; Lecturer on Public Health, London Hospital Medical College, etc. Third edition, revised and enlarged. 12mo., 527 pages. Published by P. Blakiston's Son & Co., 1012 Walnut Street, Philadelphia. Price, \$2.00 net.

Although purity of water supply is universally regarded as a most important factor in the preservation of the health of the community, the means by which such a desirable condition can be secured do not seem to be generally known. The main object of this little book is to give just such information, especially to place within the reach of all persons, particularly those interested in public health, the information requisite for forming an opinion as to whether any supply or proposed supply is sufficiently wholesome or abundant, and whether the cost can be considered reasonable. The information given will be found especially valuable for those interested in the water supply of small villages and rural districts the residents of which are obliged to depend principally upon improperly constructed and unprotected shallow wells, or even upon more questionable sources, for its supply.

The third edition is brought thoroughly up-to-date, and includes additional chapters on the protection of water supplies.

A Reference Handbook of the Medical Sciences, Embracing the Entire Range of Scientific and Practical Medicine and Allied Science. By Various Writers. A New Edition, completely revised and re-written. Edited by Albert H. Buck, M.D., New York City. Volume III. Illustrated by chromo-lithographs and 676 half-tone and wood engravings. New York : Wm. Wood & Co. 1901.

The value of this gigantic work becomes increasingly evident with the appearance of each succeeding volume, although its full utility will not be appreciated until the reader has before him the concluding volume, with its index. Volume III, as did its predecessors, consists of a number of most valuable monographs, themselves special treatises. We would direct special attention to the articles on Diseases of the Ear, the Cranial Nerves, Eczema, Diseases of the Cornea, Diseases of the Conjunctiva, Dislocations, Diphtheria, Medical Electricity, Chorea, etc. Plate XXIV gives ten illustrations of the principal affections of the cornea in colors, and with such clearness as to be of the greatest assistance to the general practitioner in making his diagnosis.

Manual of the Essentials of Diseases of the Eye and Ear. By J. H. Buffum, M.D., Professor of Ophthalmology and Otology in the Chicago Homœopathic Medical College ; Ophthalmic and Aural Surgeon to the Chicago Homœopathic Hospital and Dispensary ; Consulting Oculist to the Chicago Baptist Hospital, etc. With illustrations in black and chromolithograph. Chicago : Halsey Bros. & Co. 1901. Cloth, \$1.50 ; flexible leather, \$1.75

This little manual was prepared at the earnest solicitation of the author's classes. It presents the essential diagnostic and therapeutic points of the various diseases of the eye and ear arranged in the form of questions and answers. The anatomy, pathology and refraction have been given as full consideration as possible, consistent with brevity. The author does not contend that this little literary venture shall be used as a substitute for the larger treatises, but rather as an introduction to the study of diseases of the eye and ear by the medical student and general practitioner.

The publisher's part of the work is up to the high standard demanded by the author's literary excellence and scientific accuracy.

The Four Epochs of Woman's Life. A Study in Hygiene. By Anna M. Galbraith, M.D., author of "Hygiene and Physical Culture for Women" ; Fellow of the New York Academy of Medicine ; Ex-President of the Alumnae Association, Woman's Medical College of Pennsylvania ; Attending Physician, Neurological Department New York Orthopædic Hospital and Dispensary. With an introductory note by John H. Musser, M.D., Professor of Clinical Medicine, University of Pennsylvania. Philadelphia and London : W. B. Saunders & Co. 1901.

Much of the ill-health among women may be traced to insufficient or improper knowledge and to obstetric injuries. With the increased skill of obstetricians, the latter cause is becoming less and less important, while the former remains as great as ever. To ignorance may be traced the many nervous disturbances arising from bad sexual hygiene, transmission of venereal diseases resulting in salpingitis, and the pelvic neuroses. It is the author's object to furnish the information that will thus safeguard the health of woman-kind.

A Treatise on Surgery, by American Authors, for Students and Practitioners of Surgery and Medicine. Edited by Roswell Park, A.M., M.D., Professor of Principles and Practice of Surgery and of Clinical Surgery in the Medical Department of the University of Buffalo ; Member of the Con-

gress of German Surgeons; Fellow of the American Surgical Association, etc. Third edition, enlarged and thoroughly revised. With 692 engravings and 64 full-page plates in color and monochrome. New York and Philadelphia: Lea Brothers & Co. 1901. Price, Cloth, \$7.00; Leather, \$8.00.

The third edition of this work on surgery appears within two years after the publication of its predecessor, this fact alone attesting the appreciation of the editor's efforts on the part of the profession. The present volume elaborates on its predecessors in the chapters devoted to practical bacteriology, auto-intoxication, the surgical sequelæ of non-surgical diseases, and the surgical pathology of the blood. The lamented deaths of Drs. J. H. Etheridge and H. H. Mudgett have compelled certain changes in the corps of authors. The chapter on surgical gynæcology has been most ably prepared by Dr. Montgomery A. Crockett, of Buffalo, and the chapters on fractures and dislocations have been revised by the editor. Dr. Harvey R. Gaylord has rendered important assistance in the revision and illustration of certain chapters, especially the one on tumors, with the advance of our knowledge of which he has had much to do. The subject of blood examination applied to surgery has developed an importance warranting a special chapter, not contained in previous editions, and contributed to this one by Dr. Irving P. Lyon.

As the title-page indicates, the book is profusely illustrated, and in a manner both artistic and instructive. Certainly no medical work was ever published on such a large scale and at such a low price as Park's "Surgery."

A Dictionary of Practical Materia Medica. By John Henry Clarke, M.D. Vol. I., A to H. London: The Homœopathic Publishing Company. 1900.

It would be impossible to form a just estimate of the value of this splendid work from a merely casual glance here and there throughout its thousand pages. It is a book that one must study before he can fully appreciate its worth. Written by a man who believes that we must individualize our cases, and not allow our conception of our remedies to be limited by any list of nosological terms, one of the strongest points about the book may be said to be its effort to bring out clearly the individuality of each remedy considered. This makes it a readable *Materia Medica*, one that can be taken up by the tired doctor, who will find it more than interesting reading for odd moments of leisure. Indeed, the feature of the work that pleases us best of all are the author's remarks upon the leading individual features of each remedy, which appear under the heading, "Characteristics." These are enough to make anyone wish to possess the book. Then follows a section upon the relationship of the remedy under consideration to other remedies, and such knowledge is of real value to the homœopath in practice; because, very often, when one remedy has seemingly exhausted its beneficial action upon a case, he wishes to know of another remedy that will be likely to follow well and, as it were, complete the action of the former. The schematized list of symptoms which comprises the body of the work is full and accurately compiled from such standard authorities as Allen and Hering.

There may be found in this work many of the observations of that original worker, Dr. Robert T. Cooper. That these are valuable cannot be doubted. As an instance might be mentioned: *Agraphis Nutans*, the bluebell, a remedy not on our list of polycrests; and yet it ought to be, if it will cure adenoids with enlarged tonsils, as Dr. Cooper says it will. Dr. Clarke regards it as one of the leading remedies in cases of adenoids. We believe that this *Materia Medica* will be a valuable addition to the library of any physician. Though bulky, the volume is strikingly light in weight and easy to handle.

An American Text-Book of Pathology. Edited by Ludvig Hektoen, M.D., Professor of Pathology, Rush Medical College, Chicago; and David Riesman, M.D., Professor of Clinical Medicine, Philadelphia Polyclinic. Handsome imperial octavo of 1245 pages, 443 illustrations, 66 of them in colors. Philadelphia and London: W. B. Saunders & Co. 1901. Cloth, \$7.50; Sheep or half-Morocco, \$8.50 net.

The importance of the part taken by the science of pathology in the recent wonderful advances in practical medicine is now generally recognized. It is universally conceded that he who would be a good diagnostician and therapist must understand disease—must know pathology. Indeed, we might say that clinical medicine consists of anatomy, physiology and pathology, interpreted by common sense. The present work is the most representative treatise on the subject that has appeared in English. It furnishes practitioners and students with a comprehensive text-book on the essential principles and facts in General Pathology and Pathologic Anatomy, with especial emphasis on the relations of the latter to practical medicine. Each section is treated by a specialist who is thoroughly familiar with his particular subject, and can best frame the theories and conclusions in an authoritative form. The illustrations, which are nearly all original, and of which 66 are in colors, are unsurpassed in beauty by those in any similar work in the English language. In fact, the pictorial feature of the work forms a complete atlas of pathologic anatomy and histology.

Saunders' Question Compends—Essentials of Physiology. Prepared especially for Students of Medicine; and arranged with questions following each chapter. By Sidney P. Budgett, M.D., Professor of Physiology, Medical Department of Washington University, St. Louis. 16mo volume of 233 pages, finely illustrated with many full-page half-tones. Philadelphia and London: W. B. Saunders & Co. 1901. Cloth, \$1.00 net.

This is an entirely new work and a worthy accession to Saunders' excellent series of Question Compends. It aims to furnish material with which students may lay a broad foundation for later amplification, and serve as an aid to an intelligent consultation of the more elaborate text-book. The subject of Physiology is covered completely, and, the author of the work being a teacher of wide experience, the salient points are particularly emphasized. An important feature is the series of well-selected questions following each chapter, summarizing what has previously been read, and at the same time serving to fix the essential facts in the mind. Nearly all the illustrations are full-page half-tones, and have been selected with especial thought of the student's needs. In every way the work is all that could be desired as a student's aid.

New York Letter.—The New York Pedological Society (Homœopathic) met at the residence of Dr. Deschere on the evening of November 20th. Dr. F. W. Hamlin read a paper on infant feeding, which was freely discussed by the various members present. All the officers were re-elected, viz.: Dr. F. W. Hamlin, *President*; Dr. J. T. Simonson, *Vice-President*; Dr. J. E. Ambler, *Secretary and Treasurer*.

The financial condition of the society was so good that dues for the coming year were remitted.

It was voted to have meetings only once in two months during the coming year. Heretofore the Pedological and the Materia Medica Societies have met on the same evenings and at the same place, one at 8, the other at 9.30. In the future they will meet on alternate months.

The New York Homœopathic Materia Medica Society met at the residence of Dr. Deschere on the evening of November 20th. A number of verifica-

tions were discussed by the members present. The annual meeting will occur in December.

The Academy of Pathological Science met at the residence of Dr. G. W. Roberts, 170 West Fifty-ninth Street, on the evening of November 22d. The following officers were elected: *President*, G. F. Laidlaw, M.D.; *Vice-President*, R. R. Trotter, M.D., of Yonkers; *Secretary and Treasurer*, W. S. Mills, M.D.; *Recording Secretary*, Nathaniel H. Ives, M.D., of Mount Vernon; *Pathologist*, G. S. Harrington, M.D.; *Curator*, R. M. Jones, M.D.

After the election the following cases were presented and discussed: "Meningeal Tuberculosis" (Specimen), and "Foreign Bodies" (Non-Pathogenic), by George F. Laidlaw, M.D.; "Pregnant Fibroid Uterus" and "Dermoid Cyst," by E. G. Tuttle, M.D.; Specimen from Metropolitan Museum, by W. S. Mills, M.D.

The usual collation was served at the close of the meeting.

The annual meeting of the Homœopathic Medical Society of the County of New York took place on the evening of December 12th. Drs. Bert B. Clark and Sophie B. Scheel were elected to membership.

The various annual reports were presented, and several changes were made in the constitution and by-laws. The office of librarian was abolished and that of necrologist substituted.

It was also voted that the president should appoint a nominating committee of five in January, other than members of the executive committee; the nominating committee to report in November of each year a list of candidates for office for the ensuing year.

It was also decided to send no more delegates to the State society.

The following officers were elected for the ensuing year: *President*, Dr. Wm. H. Van den Burg; *Vice-President*, Dr. George W. Roberts; *Secretary*, Dr. J. Perry Seward; *Treasurer*, Dr. Charles Ver Nooy; *Necrologist*, Dr. John Hutchinson; *Censors*, Dr. L. L. Danforth, Dr. Geo. F. Laidlaw, Dr. Geo. W. McDowell, Dr. Edwin D. Simpson, Dr. Irving Townsend.

J. Keasbey Weatherby, M.D., Hahnemann of Philadelphia, class of 1900, Metropolitan Hospital, 1901, is now resident physician of Oak Hill Sanitarium, Montclair, N. J.

Dr. John E. Wilson, formerly of Bloomfield, New Jersey, has located at 23 East 45th Street. Nervous and mental diseases exclusively.

Dr. Henry Clarke Houghton, one of the best-known homœopathic physicians in this country, died on Saturday afternoon at his home, 7 W. Thirty-ninth Street. He was 64 years old, was born in Roxbury, Mass., and, after a business education at the Ridgewater Normal School, began his medical studies in the Maine Medical School. Later he went to the Portland School of Medical Education, from which institution he entered the New York University, where he was graduated with the degree of M.D. in 1867. Two years before his graduation he married Mary Ella Pratt, daughter of Thomas and Mary Buckram Pratt, of Yarmouth, Mo. She died three years ago. He was married a second time, July 25, 1901. From 1861 till 1863 Dr. Houghton taught natural science in the North Yarmouth Academy, and during the last two years of the Civil War he served on the United States Christian Commission. In 1868 he became surgeon to the New York Ophthalmic Hospital. When he died, Dr. Houghton was professor of otology in the New York Homœopathic Medical College and in the New York Medical College and Hospital for Women. He was dean and professor of otology at the New York Ophthalmic Hospital. He had been president of the New York State and New York County Homœopathic Medical Societies. Dr. Houghton was the author of "Lectures on Clinical Otology" and various other works bearing on his specialty as an aurist. He was a member of the Congregational and New England societies.

After a delay so long that many persons had despaired of the adoption of the project, the Municipal Council has authorized the issuance of bonds to the amount of \$275,000 for the new Harlem Hospital, Lenox Avenue and 136th Street. This is of interest to the homœopathic profession because the present administration has promised them half of the proposed hospital. Whether the new reform administration under Mayor Low will fulfill that promise remains to be seen. At any rate, a determined effort will be made to get a foothold.

Ward's Island-Metropolitan Hospital Alumni Association.—The sixth annual meeting and dinner of the Ward's Island-Metropolitan Hospital Alumni Association was held at the Hotel Marlborough on Wednesday evening, December 4th.

A number of new men were elected to the association, and the four men who finished their hospital course in June and the four who finished in December became members in course.

The Historian, Dr. Walter Sands Mills, gave an outline of the hospital events of the past year. In February Dr. G. B. Durrie ceased to be a member of the Medical Board, and on May 1st Dr. C. W. Cornell died.

A year ago, so far as the Historian could ascertain, there were 151 living graduates of the hospital. Since then there have been eight new graduates and one death, making a total of 158 now living.

The dinner was presided over by Dr. Charles H. Helfrich, the President. Dr. Gove S. Harrington acted as toastmaster. The following toasts were responded to: "The Old Hospital," by Dr. J. D. Madden; "The New Hospital," by Dr. Herbert P. Leopold; "The House Staff," by Dr. G. De Wayne Hallett; "The Medical Board," by Dr. Charles C. Boyle; "The Ladies," by Dr. H. M. Bunting.

Among those present were: From New York City, Drs. E. D. Klots, B. G. Carleton, G. T. Stewart, W. F. Honan, W. S. Mills, C. C. Boyle, J. Arscha-gouni, C. E. Teets, M. R. Bren, H. Rickaby, C. L. Bagg, G. S. Harrington, C. H. Helfrich, V. A. H. Cornell, F. W. Cornwell, W. M. Van Zandt, G. de W. Hallett, A. C. Wallin, B. D. Walker, J. B. Palmer, J. H. Demarest, H. I. Ostrom. From Brooklyn, Drs. W. H. Aten, W. B. Beck, R. N. Denison. New Rochelle, N. Y., Dr. D. J. Roberts. Yonkers, N. Y., Dr. R. P. Fay. Ossining, N. Y., Dr. J. D. Madden. Flushing, N. Y., Dr. W. E. Foster. Brewster, N. Y., Dr. L. G. Newman. From Philadelphia, Drs. T. H. Carmichael, H. P. Leopold, W. D. Carter. From Norristown, Pa., H. M. Bunting. From Scranton, Pa., Dr. J. L. Peck. From Asbury Park, N. J., Dr. J. G. Jackson. From Orange, N. J., Dr. E. V. Moffat. From East Orange, Dr. A. F. Thompson. From Montclair, Drs. H. W. Foster, J. K. Weatherby, and I. A. Meeker. From Cape May, Dr. W. H. Phillips. From Morristown, N. J., Drs. J. H. Coghlan and H. A. Newbold. From Forked River, N. J., Dr. G. E. Wallace. From Stamford, Conn., Dr. Everett Rowell. From Norwich, Conn., Dr. C. E. Stark. From Washington, D. C., Dr. Otto Somner.

Personals.—Dr. Guy Coulter died in Columbus, Ohio, November 12th.

Dr. Wm. P. Lang, of Philadelphia, has been appointed to the staff of the Metropolitan Hospital, New York City.

Dr. Raymond A. Race has removed from Rochester, N. Y., to 513 Columbia Street, Lafayette, Indiana.

Dr. Bradley H. Hoke has removed from Frederick, Md., to Lititz, Pa.

Dr. B. K. Wilbur, for several years surgeon to the Indian Training School at Sitka, Alaska, has returned, and is located at Bryn Mawr, Pa.

Mr. and Mrs. Daniel Porter Leas announce the marriage of their daughter Florence to Dr. Gustave A. Van Lennep on Tuesday, December 17th.

For Sale.—Residence and long established practice of the late Dr. Anna E. Griffith, corner Fourth and Pearl Streets, Camden, N. J. Address J. B. Griffith, Lewistown, Pa.

Washington Notes.—*The Washington Homœopathic Medical Society.*—The first fall meeting of the Washington Homœopathic Medical Society took place in the banquet hall in the Hotel Shoreham, on October 8th. After transacting the routine business, Dr. O. H. Somers, graduate of the Southern Homœopathic Medical College, was admitted to membership, following which the bureau of the evening reported, and in the absence of Dr. S. S. Straus, who was to read a paper on the "Medical Aspect of Gunshot Wounds of the Abdomen," Dr. Crichton presented a short paper on "Gangrene and its Causes, with Special Application to the Late President's Case." This was very generally discussed, taking up the remainder of the evening. Among those participating were: Drs. Macdonald, Gilbert, J. B. Gregg Custis, Hawxhurst, Corry, Krogstad, Frank, Andrews and G. W. N. Custis.

The regular monthly meeting of the Washington Homœopathic Medical Society was held at the Hotel Shoreham, November 5, 1901. The meeting was given up to a symposium on "Enteric Fever," able papers being presented on this subject by Drs. Hawxhurst, Kingsman and Wilson, following which a wide discussion was indulged in by various members of the society, after which Dr. Bishop read a paper upon some of the etiological factors of neurasthenia, Dr. Munson dealing with the diagnosis, while Drs. Gardner and Marvin Custis presented papers on the treatment, the former confining his remarks to the dietetic methods. All papers were well handled, and met with thorough discussion, among those participating being Drs. Moffitt, Gilbert, Gibbs, Krogstad and Andrews.

Government Hospital for Insane.—Ground has been broken for an addition to this hospital, for which the recent Congress appropriated \$1,000,000. According to the present plans, the extension is to include accommodations for 1000 patients and 200 employees. The Trustees will now recommend additional appropriations of \$145,000 for an administration building, \$150,000 for a central heating and power plant, \$20,000 for additional kitchen facilities, and \$495,000 for the care of 2250 inmates, at an estimated cost of \$220 per capita.

Army Changes.—Lieutenant-Colonel Ezra Woodruff, Deputy Surgeon-General U. S. Army, was placed on retired list October 24th.

Dr. Charles H. Andrews, Acting Assistant-Surgeon U. S. Army, was appointed Major and Surgeon of Volunteers, November 2, 1901.

Freedmen's Hospital.—Dr. William A. Warfield, surgeon-in-chief to Freedmen's Hospital, in his annual report recommends the erection of a new building large enough to gather the various wards of this institution under a single roof, and equip it with the needed modern appliances. The present structures are old frame buildings, difficult to ventilate and heat, and more or less inaccessible. During the past year the hospital has cared for 2552 in-patients and 5084 ambulatory cases.

Health of U. S. Army.—Surgeon-General Sternberg, in his annual report to the War Office, states that the health of the army has been exceptionally good for the calendar year of 1900. The admission rate to hospitals from all causes, volunteers and regulars, with a mean strength of 100,389 in 1900 was 2311.8 per thousand of strength, as compared with 2178.1 in the previous year. In the Philippine Islands, with a mean strength of 66,882, the admission rate was 2621.96, as compared with 2395.52 in the previous year, this

being chiefly due to disease among the volunteers, the ratio of which rose from 1859.21 to 2761.79.

The death-rate in China was large, 47.76 per thousand strength—23.62 from disease and 24.14 from injury. The health of the troops in Cuba during the year was excellent, as a result of American occupation and improved sanitation in the cities and towns on the island.

Dr. Waldeyer's Washington Visit.—Dr. Heinrich W. G. Von Waldeyer, President of the Berlin Academy of Sciences, was in Washington October 30th. He was received and entertained by Dr. Charles W. Stiles at his residence, after which he was warmly welcomed by the students of Georgetown Medical College, whom he addressed in German, his remarks being translated by the Dean of the College, Dr. George M. Kober. After a reception by the president he was tendered a luncheon by the Jesuit College. Following this a reception was given him at the Department of Agriculture and a dinner at the Cosmos Club, at which many prominent men in professional circles were present.

Diphtheria and Scarlet Fever in the District.—Diphtheria is on the increase in Washington; 60 cases are reported isolated in thirty-three houses. Of scarlet fever there are 23 cases, and of small-pox 9 cases.

Hospital Appointments.—Drs. John W. Mitchell and William H. Hughes, both of Washington, have been appointed assistant surgeons to Freedmen's Hospital.

Ask Adequate Remuneration.—The Board of Medical Supervisors of the District, in its annual report calls the attention of the Commissioners to the fact that no provision is made for the adequate compensation of the various boards of medical examiners, or the Board of Medical Supervisors. The members of the boards perform their duties solely in the interest of the public, and, under existing law, receive for their services whatever happens to be left over from the fees paid by applicants for licenses after the necessary expenses of the board have been deducted. No member of the board of eclectic medical examiners has received a cent for his services. The average amount received per annum by each member of the board of homœopathic medical examiners has been \$1.75; by the lay members of the Board of Medical Supervisors, \$20, and by the members of the Board of Medical Examiners, \$32.14. The total number of applications is 1559, and the total number of licenses issued is 1411. It therefore requests that provision be made to pay each member of the Board of Medical Supervisors and each member of the Board of Medical Examiners \$10 for each meeting attended.

Macpherson Crichton, M.D.

CORRESPONDENCE.

To the Editor of Hahnemannian Monthly: The Medical Board of the Metropolitan Hospital, Department of Charities, Blackwell's Island, disavows any connection with the alleged discoveries of Dr. Wilfred Fracliek in regard to the treatment of tuberculosis and other diseases, and is in no way responsible for the publicity of the same.

By order of the Medical Board,

Arthur T. Hills, M.D.,

Secretary.

The Southern Homœopathic Medical Association.—The Southern Homœopathic Medical Association met in its eighteenth annual session at the Aragon Hotel, Atlanta, Ga., October 10th. Dr. Susan B. Hicks, of Atlanta, called the convention to order, in the absence of President V. H. Hallman, of Hot Springs, Ark., who did not arrive in time.

Dr. C. B. Wilmer opened the convention with prayer. Mayor Livingston Mims delivered the address of welcome to the visiting doctors. The mayor was in splendid humor, and stated to the convention that he always talked law to doctors and medicine to lawyers. The mayor extended a cordial welcome to the members of the convention.

The response to the address of Mayor Mims was made by Dr. Eldridge Price, of Baltimore. He outlined in a brief speech the object of the convention, and in conclusion thanked the mayor for the many kind things said about the members.

Dr. Hallman, the President, arrived at noon, and presided at the afternoon session.

During the morning and afternoon some interesting papers were read. The programme: Address of President; "Facts, Fallacies and Fads in Gynæcology," by Dr. Lizzie Gray Gutherz, of St. Louis; "Gynæcology vs. Homœopathy," by Dr. Alfred M. Duffield, of Huntsville, Ala.; "Three Clinical Cases," by Dr. Sarah K. Millsop, of Bowling Green, Ky.; "Hysterectomy—Which Way?" by Dr. L. C. McElwee, St. Louis, Mo.; "Some Medical Features of a Great Conflagration," by Dr. Henry R. Stout, of Jacksonville, Fla.; "Clinical Cases," by Dr. W. L. Morgan, of Baltimore, Md.; "Homœopathy: The Early and Modern Obstacles in the Way of Its Progress," by Dr. John H. Henry, of Montgomery, Ala.; "Chronic Malaria," by Dr. H. C. Allen, Chicago, Ill.; "Malarial Fever," by Dr. Sarah L. Robb, of Gainesville, Fla.; "Modified Milk," by Dr. Frank Kraft, of Cleveland, Ohio; "Morning Sickness," by Dr. J. A. Whitman, of Beaufort, S. C.; "The Curability of Pulmonary Tuberculosis," by Dr. Frank Webster, of Norfolk, Va.; "Homœopathic Therapeutics in Surgery," by Dr. C. E. Fisher, of Chicago, Ill.; "La Grippe," by Dr. Jennie Brush, of Daytona, Fla.

Committees on registration, legislation and medical literature were appointed. The two subjects discussed were materia medica and surgery. A number of papers, eliciting considerable interested discussion, were read, and the papers of Dr. H. M. Paine and Dr. Susan M. Hicks, of Atlanta, and Dr. Henry R. Stout, of Jacksonville, received marked attention and were enthusiastically applauded. Under the head of surgery, Dr. Charles E. Walton, of Cincinnati, Ohio, read a paper on "The President's Case," which endorsed the treatment. This paper was also well received, and many of the delegates took occasion to speak on it.

Dr. Susan B. Hicks, of Atlanta, was elected President. The election of Dr. Hicks is the first instance on record where a woman has been made president of a medical organization. Dr. Hicks is an Atlanta woman, and is the first woman to receive such recognition.

The election of Dr. Hicks was unanimous, every member of the society present answering "Yes" in very emphatic tones when the roll for the election of president was called. Dr. Hicks is well known in Atlanta, and is regarded by the members of the convention here yesterday as one of the ablest women doctors in America. She has an extensive practice in Atlanta, and is very popular among all classes of people. Her election is a decided compliment, and she was the recipient of many congratulations. She has been one of the vice-presidents of the organization for the past year.

The other officers elected were: Dr. George S. Coon, of Louisville, *First Vice-President*; Dr. J. A. Whitman, of Beaufort, S. C., *Second Vice-President*; Dr. A. S. Duffield, of Huntsville, Ala., *Treasurer*; Dr. J. E. Mann, of Louisville, Ky., *Recording Secretary*; and Dr. Lizzie G. Gutherz, of St. Louis, *Corresponding Secretary*.

Northwestern Ohio Homœopathic Medical Society.—The annual meeting of the Northwestern Ohio Homœopathic Society was held Dec. 10th, at Toledo, Ohio, and was brought to a very successful as well as pleasant close with a dinner given at the Toledo Club by the local members of the society in honor of the visiting members.

The dinner, followed with two addresses by out-of-town speakers, formed a very fitting culmination to the meeting of the society, which was held in the National Union auditorium. Nearly fifty were present and enjoyed the hospitality of the local society, included among whom were several ladies and other guests of the society.

The dinner, a very elaborate one, was served in a happy manner in the commodious dining-hall of the Toledo Club house, after which President J. H. McVay, who acted as presiding officer, introduced Dr. J. C. Wood, of Cleveland. The address which then followed was on "The Five Great Events in the History of Medicine," and outlined these five great events as being the discovery of the circulation of the blood in the human system, vaccination, the discovery of ether and chloroform as anæsthetics, micro-organisms in disease, and the promulgation of homœopathy. The address was a very interesting one, and exceedingly well presented. Dr. Wood included in his address an extended invitation for all present to attend the next meeting of the society, which will be held in Cleveland next June.

The other address of the evening was given by Dr. Charles Gatchell, of Chicago. He spoke on the methods of widening the influence of homœopathy and the means of propagating the school.

Dr. H. F. Biggar, of Cleveland, also made a few remarks.

The after portion of the evening was given to a reception, after which many of the visiting members left for their homes. Those present were:

Drs. C. B. Kinyon, Dean M. Smith and W. A. Dewey, Ann Arbor; J. C. Wood, J. R. Horner and H. F. Biggar, Cleveland; F. W. Knight, Portage; C. H. Spencer, Bowling Green; L. M. Bunnell, Scranton, Pa.; L. Gillard, Sandusky; Dr. Damon, Rossford; J. H. Johnson, Wauseon; Dr. Chapin, Defiance; J. W. Crismore, Helena; C. S. Sawyer, Marion; M. P. Hunt and W. B. Carpenter, Columbus; Mabel Dixey, Fremont; Dr. Barnhill, Findlay; Dr. Bowman, Upper Sandusky; Dr. Rhonehouse, Maumee; Misses Jessie Dowd and Matilda Campbell, Mrs. L. K. Maxwell, Mrs. Claypool, Mrs. (Dr.) Humphrey, Mrs. (Dr.) Goodwin, Mr. and Mrs. Geo. Webber, Mr. and Mrs. Crumaugh, Mr. and Mrs. H. P. Crouse, Mrs. (Dr.) Kinyon, and the following doctors from Toledo: C. E. Stafford, F. A. Stafford, C. H. Strong, C. A. Roll, L. C. Maxwell, J. H. McVay, H. M. Flower, E. M. Goodwin, Dr. Watts, Dr. Walker, Dr. Simmons, M. H. Parmelee, A. T. Barnum, O. C. Rees, Emma B. Hays, Dr. Dawley, W. A. Humphrey, Sarah Davies, Emma Butman, Dr. Shepherd, Dr. Buckman, Dr. Kirch, Mary Munson and F. A. Crawford.

Dr. McVay, in calling the meeting to order, said in part:

"As homœopaths, better organization is needful for our existence; it is absolutely essential for our deserved growth. As physicians we need organization to protect ourselves against such parasites and barnacles as Christian Science and osteopathy, which sap our vitality and impede our progress.

"Surely all will grant the organization is needful. Our sole excuse for separate organization is our principle of prescribing. The question arises, do we devote enough time and energy to our materia medica? Is our school growing at the rate it has done in years past, and as it should do? If so, what are the causes?

"I am not a pessimist, but I honestly believe that the question put must be answered in the negative. The causes, of course, are manifold.

"In the first place, the greatest reason why more time is not spent on *materia medica* is because during the past twenty five or thirty years the medical profession has been intoxicated with the developments of science looking to the cause of disease. Practically the whole knowledge of surgery, pathology, bacteriology and biology has been evolved within that time. Most of the thought and work of men has been directed along these lines, with little or nothing at the curative end. The revelations of science have fairly taken away the breath of all humanity, and not the medical profession alone.

"The cause of disease, pathological structure, biological development, physiological processes and chemical affinities are now fairly well established. It is time we settle back and down to more *materia medica*.

"The conditions which confront the medical profession to-day are probably more disheartening than ever before in the history of the race. Medical men have done much more for humanity during the past generation than during any century before, but the public expects even greater things.

"There is a great wave of unrest in the minds of people towards the science of healing. As a consequence, Christian Science, osteopathy, divine healing, physical culture and a score of other cults flourish in our midst because the people are looking for more and better results than the medical profession is giving them.

"There is a force in the human economy which the Christian Scientists utilize. We, as physicians, should recognize it and use it where it is applicable. There is some virtue in osteopathy. We should incorporate its useful features into our armamentarium. And so on through the entire list, our duty is to recognize the good and leave out the useless.

"But with all our adjuncts the great foundation corner-stone, our *materia medica*, needs our best work. It requires repairing and revising in the light of present-day knowledge.

"A movement is on foot with this end in view. It should have the hearty assistance of every college and of every homœopath. Further, in every locality we should have *materia medica* and clinical societies, meeting frequently—at least once a month.

"My colleagues in Toledo are as able and clever a set of men, with an unusually small amount of inharmony, as can be found in any city. But it is next to impossible to get more than a half dozen to show the slightest interest in united medical work. Another effort will soon be made in Toledo for the maintenance of a *materia medica* and clinical society meeting every month."

The first paper of the morning was on the "Treatment of Acute Rheumatism." It was prepared by Dr. W. B. Hinsdale, of Ann Arbor, but as that gentleman was absent, it was read by Dr. W. A. Dewey. The discussion which followed was led by C. Zbinden, of Toledo.

Dr. F. C. Crawford, of Toledo, read a paper on "Endocarditis," and Dr. Owen C. Rees led the discussion. "Nephritis" was discussed in a paper read by Dr. L. K. Maxwell. There was an interesting discussion on this subject, in which Dr. Biggar, of Cleveland, took a prominent part.

After the noon adjournment several subjects relating to the treatment of the eye, ear, nose and throat were taken up, Dr. W. C. Copeland, of Ann Arbor, reading a paper on the subject, "Something New for the Practitioner." Dr. J. H. Harvey led the discussion.

Dr. C. E. Sawyer, of Marion, read a paper on the subject "Myomectomy, with Case." The discussion was led by Dr. H. F. Biggar, of Cleveland. Dean T. Smith, of Ann Arbor, read a paper on the subject, "Septic Wounds and Sinuses." Dr. Hunt, of Columbus, led the discussion on this. "Homœopathy in Surgery" was the subject of a paper by Dr. H. M. Flower, Dr. Goodwin leading the discussion.

The first paper on *Materia Medica* was by Dr. Dewey, of Ann Arbor, his subject being "Practical Pointers in Potency." Dr. L. C. Barnhill, of Findlay, led the discussion. Dr. Carpenter, of Columbus, read a paper on "Anti-Toxin, a Protest." The discussion was led by Dr. Stafford, of this city, who favored the use of antitoxin.

Gynæcology was next taken up, and Dr. M. H. Parmelee gave some experiences with the new hæmostatics. C. B. Kinyon, of Ann Arbor, led the discussion.

A committee consisting of Dr. Dewey and Dr. Kinyon made a very complimentary report on the President's address.

Dr. J. Ritchie Horner presented a memorial on the death of Dr. John A. Gann, who died recently at Wooster. This was adopted, and a copy will be sent to the family.

The following new members were received into the society: Drs. C. B. Kinyon, Ann Arbor, Mich.; L. C. Barnhill, Findlay. F. W. Knight, Portage; E. H. Damon, Rossford; Z. W. Shepard, Toledo.

Dr. Givens' Sanitarium (Stamford Hall), Stamford, Conn., is devoted to the special care and treatment of Mild Mental Diseases, Neuroses, General Invalidism, and has a separate department for patients addicted to the use of drugs and stimulants. It is open all the year; is arranged on the cottage plan and located on a hill overlooking the city of Stamford and Long Island Sound. Comfortable, homelike surroundings, combined with the individual treatment each patient requires. The Sanitarium is 50 minutes from New York—on the N. Y., N. H. & H. R. R.

Connecticut Homœopathic Medical Society (Semi-Centennial Celebration).—The Connecticut Homœopathic Medical Society opened November 18th, at Hartford, in Unity Hall, an observance of the fiftieth anniversary of the society, which was organized November 17, 1851, and was incorporated by the General Assembly in 1864. There was a large attendance at the initial meeting in Lower Unity Hall in the afternoon, and there were several eminent members of the profession present from Boston, Philadelphia, New York and other cities. In the evening there was a large attendance at Unity Hall, where a public entertainment was provided, consisting of addresses by leading members of the homœopathic school of medical practice and singing by the Tempo Quartette of this city.

Dr. H. P. Cole read an abstract of an address on "Homœopathy in the United States, 1851-1901," prepared by Dr. T. L. Bradford of Philadelphia, who was unable to be present. It was as follows:

"Homœopathy in the United States originated from two centres: New York City and Northampton County, Pa. In the city of New York, from 1825 to 1830, Folger and Wilsey, and Gray, and Vanderburgh, and Wilson, and Channing (except Wilsey, all physicians with extensive practice) had been sitting at the feet of that brilliant Danish scholar, Hans Burch Gram, and had been investigating in a careful and scientific way the spirit of the new law of homœopathy, so lately promulgated in Germany by one Samuel Hahnemann. It is to be remembered that these, the first pupils of Dr. Gram, were neither ignorant nor credulous men. They were skilled physicians, bright men, men of note in medical ranks, friends of Hosack, who was a medical leader of that period in New York, and, withal, fair-minded men who were willing and anxious to discover a mild and certain method of healing to replace the unsatisfactory calomel, the blood-letting, and the blister. And remember that Gram himself was a very highly educated and cultivated man, one who had received high honors from the government of his own country.

"The head-roll of these State pioneers is well worthy to here be given. Homœopathy was introduced into New York State at New York City, by Dr. Hans Burch Gram, in 1825; into Louisiana at New Orleans, by Dr. Joseph Martin, of the French navy, in 1836; into Connecticut at Milford, by Dr. Federal Vanderburgh, in 1837; into Maryland at Baltimore, by Dr. Felix R. McManus, in 1836; into Vermont at Troy, by Dr. Baird, in 1838; into Rhode Island at Providence, by Dr. Louis Parlin, in 1839; into Delaware at Wilmington, by Dr. J. C. Gosewich, an Allentown student, in 1839; into Ohio at Plymouth, by Dr. Cope, a German and a high dilutionist, in 1836; into Kentucky at Louisville, by Dr. J. G. Rosenstein, who had been an allopathic physician, in 1839; into New Jersey probably at Camden, by the physicians of Philadelphia, about 1836, although it is very likely that it had been introduced into the Jersey towns near New York at a much earlier period: into Maine at Bath, by Dr. William E. Payne, in 1840; into New Hampshire at Francistown, by Dr. Moses Atwood, in 1840; into Indiana at Indianapolis, by Dr. Isaac Coe, in 1840; into Michigan at Detroit, by Dr. S. S. Hall, in 1842; into Georgia at Savannah."

John P. Sutherland, of Boston, spoke on "The Homœopathic Materia Medica," and clearly defined and explained the phrase. In elaborating his subject, he said:

"Let us glance at the foundation on which our materia medica rests. Homœopathic Materia Medica includes the records of the effects of drugs administered experimentally to animals; the effects of drugs taken accidentally or purposely in toxic doses (poisoning); the effects of drugs in large doses, administered to sick people (overdosing); occasionally the effects of ordinary doses in cases of prolonged illness where it is assumed to be possible to differentiate drug effects from disease symptoms; and lastly and chiefly, of the effects of drugs in large and small doses when taken voluntarily by people in health for the express purpose of noting these effects, what we technically know as 'provings.' The chief sources of knowledge, indeed, upon which homœopathy relies are provings and poisonings.

"These form the very foundation of Homœopathic Materia Medica; in fact the greater part of the structure itself. Simple, uncomplicated effects of drugs upon healthy human organisms are considered by homœopaths the only reliable source of knowledge concerning the substances to be used in healing the sick. No theories, no deductions, no traditions, no empiricism, no clinical experience, are, by the homœopathist's creed, admitted as worthy of reliance in furnishing the physician's armamentarium. No system of medicine ever devised by man possesses so simple, so direct, so natural a method of studying materia medica as does ours. No system of therapeutics ever had so rich, and fruitful and reliable a materia medica. No system or 'school' of medicine, therefore, ever had as indisputable and logical a right to the title 'rational' or 'scientific' as has the homœopathic, because no system or 'school' ever had a materia medica constructed so consistently in accord with the truly scientific spirit, which demands facts unchangeable, ever-demonstrable facts, as the sole foundations on which safely to build."

Dr. George F. Laidlaw, of New York, described "The Progress of Medicine in Fifty Years." He said in opening that when the mind runs back to the practice of medicine of fifty years ago, it feels as if it was approaching the dark ages. Fifty years ago typhoid fever was just being differentiated from typhus and malarial fevers, tuberculosis meant any disease that presented a nodular lesion, diphtheria was just beginning to be recognized as a clinical entity, and Listerism and asepsis were unknown. The discoveries of Claude Bernard, Henle, Marshall Hall, Helmholtz, Flourens, Broca, Waller, Schwann, Liebig,

Pasteur, Woehler, Prout, La Tour, Purkinje, Bright, Schoenlein, Alibert, Braid, Beale, Dickinson and others were referred to, and Dr. Laidlaw said that Pasteur's studies had two results. First, they inspired the English surgeon, Lister, with the thought that the putrefaction of wounds in living tissues might be prevented by keeping the injured surfaces free from the germs of decay. From the work of Lister arose modern aseptic surgery. The second result of the labors of Pasteur on fermentation was the rise of the science of bacteriology.

"The Relation of the Physician to the Patient" was the subject of the address by Dr. Prentice Rand, of Monson, Mass. The paper was full of good advice and suggestion to young doctors, and was replete with appropriate anecdotes.

Dr. George W. Roberts, of New York, read a paper on "The Progress of Surgery in Fifty Years." Dr. Roberts said, in part:

"While within the past half century science has contributed untold wealth of learning to the practical side of life, and has revolutionized the mechanical industries and created countless new commodities, still we must admit that the greatest discoveries of science were made and the greatest initiative given at a date earlier than 1850. The latter half of the nineteenth century seems to have spent its greatest force in the development of ideas which it had inherited from earlier periods—in the practical application of theories, and in rendering concrete the abstract. Like the nineteenth century progress in other matters, that of surgery has been eminently practical, but the last fifty years of surgical progress has been more than this, in that it has involved the introduction of many new thoughts and theories. It cannot be denied that the development of technical skill is an important part of scientific progress, but as a factor it is not to be compared with the enunciation of a theory or principle which in a day works a revolution in thought and practice.

"While the greatest discovery of modern times in the realm of surgery slightly antedates 1850, the introduction into general use and the perfection of methods of anæsthesia have been part and parcel of the latter half of the nineteenth century. Many are prone to regard the world's greatest discoveries as lucky hits by single individuals, but this is not usually the case, and especially is it not the case of anæsthesia. The ancients undoubtedly knew some."

The anniversary banquet was served at the Allyn House at 2.30 o'clock in the afternoon. President Sanford presided, and Dr. Edward Beecher Hooker, of Hartford, was the toastmaster. The attendance was 110, which included many ladies, wives of visiting and local physicians. The banqueters were seated at small tables, the main table at the south end of the attractive dining-room being occupied by the officers of the society, the speakers and the invited guests. Among others who occupied seats at the head table were Dr. George R. Shepherd, President of the Hartford Medical Society, Dr. Joseph E. Root, secretary of the same society, and Dr. Henry Bickford, the latter representing the eclectic school of practice and the two former the allopathic school.

West Jersey Homœopathic Medical Society.—The fall meeting of this Society was held in the parlor of the Homœopathic Hospital, in Camden, N. J., on Wednesday, November 20, 1901, at 2 o'clock, the President, Dr. Howard Iszard, in the chair.

As the treatment of small-pox, the question of vaccination, and the anti-vaccination side of the question were to be presented, and the whole question then discussed, a large attendance was expected. Fifty physicians were in attendance.

After electing Dr. Edgar Clement, of Haddonfield, a graduate of the Hahnemann Medical College of Philadelphia, class of 1898, to membership, the Society proceeded at once to scientific matters.

The President introduced the following gentlemen, who read the papers assigned to them, as follows :

1. "Small-Pox," by Dr. E. M. Gramm, member of the Bureau of Materia Medica.
2. "Vaccine Virus and its Preparation," illustrated by means of lantern slides, by Dr. W. F. Elgin, Director of Mulford's vaccine laboratory.
3. "Vaccination," by Dr. W. W. Knowlton, member of the Bureau of Surgery.
4. "Is Vaccination a Superstition, or is it the Result of Intelligent Scientific Research?" by Dr. A. S. Ironside, of Camden.

The papers were received, and the thanks of the Society extended to each writer, and then the President declared them open for discussion, and extended the courtesy of the floor to every physician present and invited all to participate in the discussion.

Dr. Wm. H. A. Fitz said : Vaccination was scientific, but he did not believe in it absolutely. We have something better in our medicines. He believes compulsory vaccination is an intolerable tyranny. In one case of variola, under variolinum, sixth decimal, the pustules soon dried up and the patient made an excellent and speedy recovery. In homœopathy we do have some scientific support against small-pox. He read an extract from one of our journals (HAHNEMANNIAN MONTHLY), where the editor said it was the duty of all to submit to vaccination. He also stated that Jenner at first claimed that one vaccination was protective for all time, but before he died Jenner eventually resorted to revaccination.

Dr. E. M. Gramm thought Dr. Ironside did wrong in comparing Jenner's experiments with Hahnemann's. Jenner did not go into it with any idea of humbug or of building up or propping up any system. It was known for years before Jenner's experiments that vaccine was preventive of small-pox. Dairy-maids were immune from small-pox on account of having had cow-pox. We ought not to go against the proper lights. The Royal Commission of England endorsed vaccination, and supported it with statistics. He thinks Dr. Ironside hedges badly when he says vaccination is unscientific, but recommends it in homœopathic preparations. He does not think the taking of a high potency of a remedy will prevent the taking of certain diseases. It was impossible to vaccinate the leprous. Before vaccination was practiced in England over 500,000 persons died annually from small-pox. It is not so now. The Mulford lymph, he believes, is the finest quality prepared to-day. It is very easy to quote a portion of a report without giving all the facts.

Dr. J. W. Thatcher said : He does not think we are all insincere in opposing vaccination. If we are believers in the homœopathic law, there must be some better way. We know that there have been some bad results from vaccination. It is no answer to say, in cases of tetanus following vaccination, that they got dirt in the wounds. Boys get scratched, roll in the dirt on the part that is scratched, but they don't get tetanus ; yet all these cases have been vaccinated. Would like to hear Dr. James on this question.

Dr. Walter M. James, in reply to this, said : It is not at all certain that the germs cause tetanus. If the yeast-plant is dropped into grape-juice, it leaves a *débris*, and the product is alcohol, bouquet of wine and water. In the case of tetanus, it is exceedingly difficult to discover the germ under the microscope. The manufacturers of vaccine do not know, when they are raising the vaccine, what other products arise. They don't know whether the vaccine is producing

ptomains or leucomains. There is a tremendous mystery in this. To turn back again to wine: when the yeast-plant is taking its food in the juice, alcohol results and destroys fermentation. So, in small-pox, the disease is self-limiting.

Typhoid fever is self-limiting; so is pneumonia. Very well. There is the small-pox germ; it gets in the system and lives there; it goes on and creates the disease we call small-pox. Wherever the germ is, it can get in in spite of the utmost care. The germ of tetanus being so minute and so difficult to detect, it gets in the virus, and goes on and develops.

He spoke of Pasteur's experiments. Pasteur, in his efforts to rid France of chicken cholera, took the cholera germ and reduced the virulence of this poison by successive passages from vial to vial, until he had reached the stage when the fluid could safely be given to the chickens, and thus rid France of the pest. Now chemists think it is better to put the matter in live animals to increase the power, contrary to Pasteur's directions. Growth in these juices causes new forms of life. He mentioned the case of the German professor in whose family a domestic had the diphtheria. She was removed from the house, and the professor, to protect his child, had antitoxin injected. This child was well, and playing round the house. In five minutes after the antitoxin was injected his child was dead. If we go on giving these poisons in such large doses, without reducing them, we are going to have such results as to cause the people to rise in revolt against us. We would not give woorari recklessly to a child; why, then, should we use antitoxin? We don't get down to the vital question, Does the product of the vaccine cause immunity?

Dr. Thatcher asked Dr. James what he would do in such cases.

Dr. James replied: What are you to do? To a homœopathic physician small-pox is robbed of fifty per cent. of its terrors. The old-school physicians, with all due respect for their scientific attainments, have nothing to rely on. In homœopathy you have a guiding star. Under our treatment small-pox becomes quite manageable. He referred to the report that a certain Mother Superior of a convent stopped the spread of small-pox by a preparation consisting largely of sulphate of zinc. There may be some truth in it. We hear of cases treated with cyanide of potassium. It is useful, but only in a limited sphere. He spoke of the use of tartaric acid by an Episcopal clergyman in England, and of the good effects from its use. You hear of cases treated by malandrinum and vaccinum and variolinum. If all this testimony comes to us at once, and we have no rule to guide us, we are like blind leading the blind. One doctor is frantic to have a case of small-pox, so he can cure it with baths of permanganate of potash. Another doctor wants a case so he can cure it with potentized tartaric acid. We have a principle, and we can select our remedy. With the wide horizon we have, the homœopathic physician should approach an epidemic of small-pox without fear.

Dr. H. Knox Stewart was much interested in the papers and in this discussion. Nowadays, with the Board of Health's regulations, we get very little to do in treating this disease. He related his experience several years ago, when he was one of the police surgeons. He never heard of tetanus in the great epidemic of 1871. Thinks much of the trouble in these cases of tetanus is caused by want of cleanliness. All the cases of sore arms he has seen have been where they used shields. Dr. C. G. Kane said he could cure every case of small-pox with malandrinum, but he wanted Tafel's five-hundredth to do it with.

On account of the lateness of the hour, further discussion of the papers was postponed until the next meeting.

Wallace McGeorge, M.D.,
Secretary.

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DISEASES OF THE NASAL ACCESSORY CAVITIES.

BY ROYAL S. COPELAND, A.M., M.D., ANN ARBOR, MICH.

(Read before the Homœopathic Medical Society of Washington, D. C., Dec. 14, 1901.)

WHAT I shall say under this title will be suggestive merely. It is only recently that special attention has been given these diseases, and we are as yet unprepared to exhaustively treat the subject. Enough has been learned, however, to prove that impairment of the general health is the effect of a long-continued suppurative process in one of the accessory cavities of the nose. Furthermore, new light has been thrown on the etiology of nasal polypi and a reasonable explanation found for the persistence of many so-called catarrhal diseases of the upper respiratory tract.

Attention to the sinuses enables us to more accurately locate the lesion in, and, certainly, to more intelligently treat our catarrhal cases. Lack of definite knowledge concerning the exact nature of the so-called catarrhs, too, has led to many disputes as to the value of this or that system of treatment. It is common practice for one physician to use certain sprays in the treatment of all such patients, while another uses the douche, and a third depends upon the internal remedy alone, claiming catarrh to be what the laity call a "blood disease" which can be treated only "through the system." It explains, too, why there is such difference of opinion, based on clinical experience, as to the class of remedies likely to prove useful in these

diseases. In the selection of the remedy, no one will deny that it makes a vast difference whether the disease is one involving the mucous membrane alone or whether the bone itself is involved. The prevalence of accessory cavity disease, even though unsuspected, explains why one man looks upon aurum, mercury and silicea as great "catarrh remedies," while another, who has dealt with catarrhal conditions involving the mucous membrane alone, considers of greater importance the more superficially acting remedies, like pulsatilla.

Therefore, in my judgment, any investigation which brings new knowledge of the pathology of these cases will assist in the cure. If the source of the suppuration is a cavity, walled off from the nasal passage proper, it requires no argument whatever to show that all sorts of sprays, douches and vapors can have no effect upon the diseased area. Before local remedies can be of any avail, surgical measures must afford a means of access to the diseased region. This must appeal to our good sense just as much as does the cutting of a hole in the siding to afford entrance to the water intended to extinguish a fire between the inner and outer walls of a house. Certainly we could not commend the judgment of a fire department which sprayed the outer bricks in the expectation of putting out a fire raging within the building.

Permit me to call to your attention the anatomy of the nasal accessory sinuses. Unless you have given this matter thought and recent study, you will meet some surprises at this point. I don't know that I ought to say this, either, because, if you are like the writer, you are surprised if *any* dry fact of the old anatomical days remains in mind. When anatomy is talked about, I am surprised if some fact is mentioned which seems familiar enough *not* to be a surprise.

We all remember, of course, that on each side of the skull there are four cavities accessory to the nose. They are the maxillary antrum, the ethmoidal cells, the frontal and sphenoidal sinuses. Examination of the sectioned skull will recall to your mind that the openings of these cavities are very close to each other. This explains why several or all of the sinuses are involved if any one of them is diseased. With one of them emptying pus into the nose, it is not surprising that the pathogenic organisms travel into the other cavities. It is true, too,

that the antrum, for instance, while really not affected, may be a reservoir of pus, the overflow from the diseased frontal sinus.

The subject is a large one, and in a paper which cannot be exhaustive it is puzzling to decide what features of it to consider. Some writers have called attention, recently, to the effect of oral sepsis upon the general health, claiming that septic gastritis, toxic neuritis, and other septic conditions, result from carious teeth. If these arguments are well founded, certainly the much greater amount of pus which results from a chronic sinusitis must produce very serious consequences.

In the introduction to Tilley's book on "Purulent Nasal Discharges" are some statements well worthy of our consideration. He says: "The importance of a purulent nasal discharge cannot be overestimated when considered in its relation to the general well-being of the individual. We may glance for a moment at the case of a patient suffering from a chronic empyema of the maxillary antrum of a few months' duration. Under such conditions there exists a reservoir of pus which is often horribly offensive, and teeming with many varieties of septic organisms in which the staphylococcus pyogenes aureus and albus and streptococci predominate. Week in, week out, morning, noon and night, the contents of this reservoir of septic matter are constantly overflowing into the nose, and, passing backwards into the pharynx, are swallowed. Fortunately, a certain amount of the poison is rendered harmless by the free hydrochloric acid of the gastric secretions; but when the quantity of pus is increased, the result is soon manifested in various forms of gastric catarrh and their associated symptoms of indigestion. . . . The general health is often profoundly affected. The appetite is gone, while nausea, flatulence and pain follow the ingestion of what little food is taken. Such symptoms, associated with a sallow complexion, loss of weight, and general lack of vitality, often present a striking resemblance to a malignant cachexia. Furthermore, the loss of energy, mental depression, and lack of interest in the affairs of everyday life, bespeak the subtle effect upon the nervous system induced by the constant absorption of septic matter into the system."

In addition to these profound general disturbances, certain

local changes follow suppuration of the accessory cavities. Grünwald maintains, and apparently the majority of the authorities now agree, that nasal polypi, in most cases, occur in connection with focal suppuration. That writer goes so far as to say that "polypi in a majority of all cases are almost as good as pathognomonic of empyemata of the accessory cavities, or focal suppuration in the nasal passages."

Ozaena is looked upon by many as nothing more or less than an evidence of focal suppuration of some sort, particularly of one of the sinuses. When present, the accessory cavities should be thoroughly examined, with a view to locating in them the site of the lesion.

The enthusiast will point to many disturbances in taste, smell and sight, as results of empyemata of the sinuses. Asthenopia, particularly, is pointed to as such a symptom. Those of us who do eye work must confess to many failures in the relief of asthenopic symptoms by the correction of errors of refraction. Progress along the line of this paper's subject may assist in relieving such cases.

We might pile up testimony to prove that this, that and the other ailment is simply a symptom of sinus disease, but enough has been said already to indicate that this subject deserves study by the surgeon, the eye, nose and throat specialist, by the neurologist, and by the general practitioner. Sinusitis has a bearing on the general health which cannot be overlooked with safety. Much has been left unsaid, and concerning treatment absolutely nothing has been attempted. Time does not permit; and, besides, the purpose of this paper is to excite discussion of the general proposition that the nasal accessory sinuses are much more frequently diseased than is generally believed. The writer has a further ambition, too, that his listeners may be led to think about these conditions, observe and study their own cases, formulate conclusions to be made public later, and so help us to accurate knowledge of the real importance of nasal sinusitis.

HÆMATOXYLON CAMPECHIAN IN DIARRHŒA OF INTESTINAL TUBERCULOSIS.—Dr. Wapler, of Leipzig (*Allg. Hom. Zeit.*), has obtained good results in painless diarrhœas of tuberculous origin, administered in the second decimal dilution. He cites a severe case with high morning and low evening temperature that was decidedly benefited.

APPENDICITIS COMPLICATING PREGNANCY.

BY WILLIAM B. VAN LENNEP, A.M., M.D., PHILADELPHIA.

(Read before the Washington Homoeopathic Medical Society, December 14, 1901.)

It almost seems to-day that an apology is necessary when a surgeon undertakes to discuss, in any of its phases, a subject so familiar and possibly so trite as appendicitis. As a complication of pregnancy, however, it appears to me, from a review of the literature of the past ten or twelve years, that appendicitis is of sufficiently rare occurrence to warrant calling the attention of the general practitioner to its possibility; because, as I shall try to show later on, it presents greater dangers both to mother and child, and greater diagnostic difficulties than when appearing at other times.

A brief reference to some anatomical points in connection with the disease in general may not be out of place, particularly as they have a bearing on the phase under consideration. Assuming that the observations of Clado are correct in the main, if not constant, we have in the first place an additional source of blood to the appendix, in the female, from the ovarian artery; in the male, as is well known, the blood supply is of the end-artery variety, and derived from the ileo-colic branch of the superior mesenteric. The fold of peritoneum described by him, and running from the meso-appendix to merge into the broad ligament, not only contains these anastomotic vessels, but, through the accompanying lymphatics, makes possible an interchange of infection between the appendix, its mesentery and the adjoining cæcum on the one hand, and the right broad ligament, with its neighboring tube and ovary, on the other. Thus we can readily see why parametric suppuration, either from the uterus or the adnexa, can rise higher on the right side, and perhaps even show itself as an abscess in the right iliac fossa. So, too, cases are on record in which appendiceal infection, instead of breaking into the peritoneal cavity, appears to have followed this lymphatic channel, or, perhaps, to have spread along the retro-peritoneal connective

tissue, down into the broad ligament, to point, as I have seen in several instances, either into the rectum or alongside the vagina into the vulva, the stercoral pus suggesting the intestinal origin of the abscess, and the examining probe or sound going as far up as the cæcum. Again, the very frequent downward and inward pointing of the organ in the female suggests the directing influence of this peritoneal fold, an element of safety, it is true, when we remember the prognostic importance of its various positions—inward and inward and upward, the most dangerous; into the pelvis, less so; and up along the lateral gutter, the safest.

While this additional vascular supply appears to account for the one to five difference in the frequency of appendicitis in the two sexes, it is generally acknowledged that pelvic disease, influencing as it must the circulation, or infecting the above-mentioned lymphatic channel, changes this disparity to such an extent as to make it a strong predisposing if not an equalizing factor. This is, moreover, borne out by the fact that the attacks of appendicitis met with in the female usually occur at such time as we may look for disturbances in the pelvic circulation; that is to say, before, during or after menstruation; and what seems still further to substantiate the observations of Clado is that, aside from the traumatic causes inducing attacks in the male, such as sprains, blows, and especially over-exertion in the sedentary, constipation and indigestion, the usual exciting conditions, are as common, if not more so, in the gentler sex. From these conclusions it seems reasonable to infer that pregnancy should have a causative relationship to this dread disease; and yet in the literature at my command it seems surprising that I can find but a little over one hundred recorded cases during the last nine or ten years. This corresponds very nearly with my personal experience, although it is possible that operators confining themselves exclusively to gynæcological and obstetrical work will find the percentage larger. A critical analysis of the published records, however, leads me to conclude that while this physiological process, like menstruation, may not in itself be a causative factor, it induces attacks where adnexal or appendiceal trouble is present beforehand. Thus, given lesions of the appendix in the shape of adhesions, kinks or stricture; given similar lesions in and about the right

broad ligament, tube and ovary, it is easy to understand how a rapidly growing uterus can accentuate each and every one of them. The constipation of pregnancy has been cited as a predisposing cause, inasmuch as it is usually present before other attacks; and some observers argue that it increases the tendency to fecal concretions in the appendix through stasis, damming back and bending; that the down-hanging organ over the pelvic brim can readily be pinched by the growing uterus, in this way verifying the favored "stercoral theory" of the French, so admirably advocated by Talamon. Again, there are those who believe that the congestion of the pelvic organs during pregnancy, together with the mechanical disturbances of the circulation, as evidenced in hemorrhoids, genital varicosities, etc., should act as it does at the menstrual periods in predisposing to appendicitis; while others, on the other hand, argue that this congestion puts the pelvic organs, as well as the appendiceal "adnex," in the most healthy possible condition. Here, too, as stated above, the presence of previous lesions, pelvic or right iliac, seems to be the determining cause.

The earlier observers of this complication, and it was probably Mundè who started the ball rolling in this country by his article in 1894, based their conclusions on cases in which the process had gone on to suppurative peritonitis, either diffuse or more fortunately limited to an abscess. In the latter instance the uterus usually formed one of the walls of the pus cavity, and therefore the question of miscarriage and the death of the fœtus from irritation and from infection was the prominent one, some even advocating the induction of abortion or premature labor, either before or after opening of the abscess. In these cases there is no doubt that such pus should be evacuated irrespective of the uterine condition; that is to say, in any stage of pregnancy, even during labor or during the puerperium, as soon as its presence and its source are recognized, perhaps even suspected. But in the absence of encysted or diffuse peritonitis the consensus of opinion concerning appendicitis complicating pregnancy goes even further than the most radical among operative surgeons demand for the disease in general, namely, that any attack should be operated as soon as the diagnosis is made. It is true that occasional cases have been reported in which, by waiting on mild seizures, so-called "catarrhal disease," the

patient has recovered, and even gone safely to term; but this advice is not too radical when we consider the mortality of appendicitis during pregnancy, which, according to different writers, varies from 35 to 50 per cent., as compared with the general mortality of the disease, all kinds of cases being included, of not more than 10 per cent. To this should be added a foetal mortality of from 50 to 85 per cent. Personally, I would even go so far as to recommend the removal of an appendix known to be chronically inflamed as soon as pregnancy is known to have begun; for the uterus, as it grows upward, will either induce attacks by displacing the organ, bending it or pinching it; or if, during the attack, the patient escapes diffuse septic peritonitis, the more fortunate abscess is apt to be torn open, and the pus diffused by the distending womb or by the contractions of labor, either at term or during the miscarriage that it has brought about.

If prompt action is required in every case, the sooner a diagnosis is made the better are the chances of recovery. Judging from personal observation, from my reading, and from conversations with colleagues, I believe the recognition of appendicitis in its early, uncomplicated stages is nearly as easy during pregnancy as in the ordinary run of cases, provided we bear in mind the cardinal signs and corroborative concomitants presumably familiar to every one. Pain must sooner or later settle subjectively in the usual location, but abdominal pain during pregnancy, and for that matter at any time, demands careful investigation; the cramps of threatened abortion or miscarriage must be distinguished from appendiceal pains by bimanual palpation, discharges, etc., on the one hand, and by *tenderness* and *rigidity* on the other. Again, indigestion being frequently the initial complexus, attacks of vomiting must not always be relegated to the phenomenon accompanying pregnancy. With this in appendicitis should be associated pain, and especially tenderness and rigidity; while the pulse is often quickened by the vomiting of pregnancy, the temperature is not affected, but in an appendicitis it is very apt to shoot up in the beginning. So, too, is the coated, flabby, pasty tongue of appendicitis a suggestive distinction, at least when the question of adnexal disease is under consideration.

The presence of a diffuse peritonitis is readily appreciated,

no matter what its source, although it is even a worse omen during pregnancy than when otherwise seen, for two lives are usually sacrificed. It is the more fortunate form of peritoneal infection, the limited suppurative variety that presents the greatest diagnostic difficulty. In the past, and even to-day, both have been and are termed pelvic abscess or peritonitis, puerperal or post-abortive "fever," the initial symptoms being considered intestinal cramps or the pains of a threatened miscarriage. More than one uterus has, to my knowledge, been everted and washed out when the cause of its emptying itself and of its infection was extra-, not intra-uterine, or, to be more specific, appendiceal. The danger of such mistakes is still further emphasized by the well-known fact that the mid-abdominal extravasations, those originating from the intestines, are always more virulent and rapidly fatal than those starting from the uterus and its appendages in the slowly-absorbing, I might almost say often previously immunized pelvis. Pinard very pertinently remarks that all the cases of peritonitis and of so-called bowel obstruction complicating pregnancy that he has seen during twenty-five years have died when treated "medically." His paper, together with recent statistics and the two appended cases, show a far better record for those treated surgically. In connection with the above-mentioned "so-called bowel obstruction," I recall, in the preface of the first edition of Treves' classic on intestinal obstruction, that "over two thousand individuals die every year in England alone from the various forms of obstruction of the bowels, exclusive of hernia." What surgeon has not been called to operate for the stercoraceous "bubbling over" of an overlooked peritonitis which has been diagnosed bowel obstruction at the eleventh hour?

The down-working appendiceal abscess can usually be distinguished from the up-spreading pelvic one by the absence of hardness and bulging in the right vaginal fornix; but the cases already referred to as pointing in the rectum or vulva presented this supposed distinctive sign, while others developing behind the enlarged uterus have been felt in the *cul-de-sac*. Another misleading symptom frequently referred to is the diffuse and even left-sided tenderness. Such an observation is familiar to every operator of experience in appendicitis, but can usually be cleared up by recognizing the location of the most exquisite

tenderness and of the most marked corroborative rigidity. Penrose reported a case some five years ago in which this board-like rigidity simulated for months a tumor extending from the rib-border to the groin, persisted during anæsthesia to the annoyance of the operator, and disappeared after the removal of a "fibrous" appendix buried in old adhesions against the *posterior* abdominal wall. Diffuse or distant tenderness is naturally to be expected in general peritoneal inflammation; and when we remember the course taken by the multiplying abscesses from a down-pointing appendix, *i.e.*, across the pelvis and up alongside the descending colon, we can readily understand that pus crowded back behind a towering uterus may cause tenderness on the left side. While I have not met with this symptom in cases complicating pregnancy, I have twice observed it in the analogous mechanical filling of the pelvis by fibroids. In one, the abscess lay in the hollow of the sacrum, completely covered by the fibroid, so that the tenderness was necessarily felt on the free left side. The uterus had to be turned out of the abdomen to get at the pus. In the other, the right pelvis was so tightly packed by the enlarged womb that the abscess, developing from the leaking tip of a down-hanging, pinched appendix, was obliged to work up into the left groin.

During the first weeks and months of gestation, ectopic pregnancy sometimes simulates appendiceal abscess. Especially is this true when the sac ruptures, distending the belly and producing the collapse which suggests the bursting of an abscess, or, if occurring very early, a fulminating appendicitis; but the intelligent exclusion of intra-uterine foetation eliminates this class of cases from our discussion to-night. A patient operated for Dr. M. L. Munson, of Atlantic City, and Dr. S. A. Beale, of Media, within the past ten days, shows similar diagnostic difficulties. A young woman presented a mass which could not be separated from the uterus, which had grown so rapidly as to correspond quite accurately with pregnancy, but without arrest of menstruation, nor the usual outlet changes beyond, perhaps, a soft cervix. She was suddenly seized with agonizing, right-sided pain, which caused fainting, after which a distinct, tender tumor developed in the right iliac fossa. When seen, the abdomen was tympanitic and sensitive; the pulse was miserable, and about 140; the temperature was up, and had been so for

several days: there was exquisite tenderness on both sides (especially the right) of the central mass, which reached to the umbilicus on a level with a tumefaction in *both* iliac fossæ. Section showed a very soft sarcoma springing from the fundus of the uterus, with a large, recent, hæmorrhagic, ruptured cyst filling the right iliac fossa, while another containing clear fluid occupied a corresponding position on the left side; a moderate serous and a faintly fibrinous peritonitis was universally present. Complete hysterectomy, accompanied by a copious washing, and followed by a generous intravenous infusion of salt solution, has brought about a brilliant recovery.

It is hardly necessary to take up your time with other conditions which must be distinguished from appendicitis in general, such as gallstone or renal colic; empyema of the gall-bladder and floating or pyonephrotic kidney; incarcerated or even strangulated hernia and bowel obstruction; typhoid fever, tubercular peritonitis, lumbar and psoas abscess; any movable organ or cyst with a twisted pedicle, etc.

The following cases, which have recently come under my care, illustrate some of the phases of the subject under consideration, as well as the results of timely surgical intervention:

CASE I.—Mrs. —, multipara, of rather spare habit, with a normally flabby and relaxed abdominal wall, was seen with Dr. W. K. Ingersoll on April 1st last. She had been sick for three or four days with abdominal pain, which she was first inclined to consider a threatening abortion, but which had gradually localized itself on the right side with the characteristic tenderness and rigidity of an appendicitis. When seen, this tenderness was exquisite, the abdomen was distended and tense, the constipation was complete, and had not yielded to the usual measures. Intestinal gurgles were very scanty, and there was diffuse pain, with a miserable “*facies abdominalis*.” The temperature was up, and, what was of still graver import, the pulse was accelerated, 120 to 130, and she was belching and somewhat nauseated. The uterine enlargement could be felt by bimanual palpation, and the cervical, vaginal and vulvar signs of pregnancy were readily recognized. According to her calculation she was three months pregnant.

She was at once transferred to a private room in the Hahnemann Hospital, and operation undertaken as soon after as possible. The abdomen was opened in the median line and found filled with a turbid, flocculent serum, both the parietal

and visceral peritoneum having lost its lustre. The appendix pointed inward and upward, was perforated at its tip, and imperfectly wrapped in the omentum. After tying off the appendix, the stump was cauterized and a toilet of the abdominal cavity instituted, iodoform gauze drainage was abundantly used, and the wound left open.

She readily responded to purgative enemata by passing gas, and by the third day the bowels were moved by laxatives. Rapid pulse and the alarming restlessness of peritonitis caused us considerable anxiety during the first three days; besides this, the urine was very scanty, but the kidneys responded to the usually indicated measures. A week later the abdominal wound was sutured under ether anæsthesia, after removing the pack, with heavy cumolized catgut, the suture being a continuous one, forward and back, layer by layer. There was no trouble after the second operation, and she went home seventeen days later completely healed. At the end of September Dr. Ingersoll delivered her of a ten-pound baby without any labor complications to mother or child, the balance of pregnancy being absolutely uneventful. She has at present a good, firm cicatrix, without any sign of hernia.

Remarks.—So far as I am able to learn this was the initial attack, the appendix in all probability having been pushed up into this dangerous position by the rising uterus. Fortunately the perforation was near the tip, extravasation being more rapid and abundant as the base is approached, and this insured sufficient delay to allow the omentum to still further retard the infective process. In spite of these fortunate circumstances, a surely fatal, diffuse peritonitis was well under way, as evidenced by the absence of protective adhesions and the clouding of the parietal and visceral layers. Wherever seen, the effused fluid contained flakes of yellow, plastic lymph, and the intestinal coils presented a similar fibrino-purulent exudate. Such cases, when ordinarily seen, are subjected by me to evisceration and scrupulous wiping, or to abundant douching with hot salt solution; if too weak for such radical measures, continuous subsequent irrigation has saved several lives in my hands. Here, however, I hesitated to use the continuous lavage for fear of inducing abortion, and her condition did not permit the more radical alternatives first mentioned. I was therefore content to mop up the fluid, wipe off the worst-looking coils, and trust to a wide-spreading, capillary, iodoform

gauze drain to suck out or wall off the remaining minimized infection. In a complete secondary suture I have the greatest confidence, and make no attempt to close an abdominal wound in septic or suspicious cases. Partial suture is almost invariably followed by hernia; while, barring the discomfort of a second anaesthesia, of which, whether with ether, chloroform and oxygen, or nitrous oxide gas, I have no fear in the hands of our expert anaesthetists, accurate approximation can be obtained three, five, seven or more days after the primary operation. I can heartily recommend this plan to my surgical colleagues after a large experience, extending over a number of years.

CASE II.—Mrs. —, 38 years old, multipara, patient of Dr. H. C. Chisolm, of Huntingdon, Pa., between three and four months pregnant, as she was seen on September 9th, and expects to be confined during February next. She had been suffering from a subacute attack of appendicitis for several days, and was brought to the Hahnemann Hospital by her physician on account of the persistence of the symptoms without amelioration and the development of bearing-down pains, which suggested a threatening miscarriage. Langenbuch's incision showed the appendix pointing inward and upward, deeply injected, with cicatricial thickening of its walls, and the characteristic club-shaped end from the retention of pus. There was a "localized" sero-purulent peritonitis, the fluid being flocculent and not encysted by adhesions. The term "localized" is used because glistening coils of intestine could be drawn out beyond those that had lost their lustre, and not because there were limiting adhesions; for this reason an iodoform gauze pack was introduced after the appendix had been tied off, and its stump thoroughly cauterized with crude carbolic acid. The after-course of the case was uneventful, beyond an alarming pulse acceleration and abdominal distention, which lasted for a day or two; the bearing-down pains also persisted during this time. Such a pulse and distention seem to indicate the presence of an infection left behind, but either drained out or taken care of by the absorbing peritoneum. The wound was allowed to heal by granulation for a time, and was then drawn together after the removal of the gauze. She returned home in perfect health four weeks after the operation, and there has not been any disturbance of pregnancy since.

Remarks.—This was a subacute attack—one of those that sneak on treacherously to a septic peritonitis, not by gangrene or perforation, usually, but by the escape of micro-organisms

through the diseased intestinal wall. These are probably the most puzzling cases to treat correctly, unless we follow the hard and fast rule laid down regarding appendicitis during pregnancy. Any further delay would have caused a fatality, as the sero-purulent peritonitis, although *localized*, was not *limited* by the slightest semblance of adhesions, recent or ancient. Both cases, while, strictly speaking, operated too late as regards the extra-appendiceal infection,—not, however, through any fault of the medical attendants,—nevertheless do not belong to the dangerous and unsatisfactory class, where the physician has calmly stood by for Nature, if lucky enough, to wall off, in her clumsy way, the process into a circumscribed abscess. This can only be evacuated, the appendix being left alone in most instances; this will irritate the gravid uterus, which usually forms one of its walls, until it discharges its contents; this, too, will kill the fetus by infection, as the presence of the common colon and other bacilli show, or by the induction of premature labor; this will cause a septicemia or a pyemia fatal to the mother, and, in consequence, to the child; this may be torn open by the rapidly contracting or more slowly enlarging uterus to produce a septic intoxication, or a diffuse, perhaps more slowly fatal suppurative peritonitis.

The conclusion is clear: Early diagnosis and immediate operation in every recognized case. If the recognition comes late, still operation, irrespective of the physiological process in the uterus, excepting those patients in whom the practised eye recognizes the fact that operation will only hasten an inevitable death, and thus reflect discredit upon our beloved, life-saving science and art of surgery. Such should be the treatment of every case of appendicitis complicating pregnancy.

REPETITION OF THE DOSE.—Dr. W. P. Wesselhoeft thinks that the physician who takes the time and care necessary to make his first prescription correctly will always be inclined to respect the pains that he has taken, and will not be likely to spoil all that he has accomplished through too frequent repetition of the dose, nor through a change of remedy. It is the almost universal mistake of beginners in the practice of homœopathy, that they must pepper their patients every hour or two with medicine. This is fatal to success, especially in chronic diseases.—*Medical Advance*.

SOME STUDIES IN PLASTIC SURGERY.

BY T. L. MACDONALD, M.D., WASHINGTON, D. C.

(Read at the Annual Meeting of the Washington Homœopathic Medical Society, Dec., 1901.)

IN the absence of a formal subject for consideration the writer wishes to report the following cases of plastic surgery.

CASE I. *Entire Absence of Genital Organs*.—Mrs. —, æt. 23, had never menstruated; had been married two weeks, and conjugation was impossible. Upon investigation she was found to be without vagina, uterus, or ovaries. She was otherwise well developed, and a fine-looking woman. The clitoris, hood, urethra and large labia were normal. There was a shallow crevice, about $\frac{3}{8}$ of an inch deep, between the labia. This was all. Both she and her husband requested that she be made as much like other women as possible.

Treatment.—Of course there is no difficulty in making a vagina, but great difficulty has been experienced in preventing it from becoming practically obliterated by cicatricial contraction. In order to obviate this, the following operation was done.

A two-and-one-half-inch incision was made transversely, just above the symphysis pubis, and was carried downward by blunt dissection. A sound was introduced into the bladder in order that the urethra might be well outlined, and hence less likely to be wounded, as the incision was being carried very close to the urethra. The suprapubic incision, being deepened sufficiently, was met by a vertical cut between the labia, and the passage then made wide and free. Two flaps, $7\frac{1}{2}$ inches long and $2\frac{1}{2}$ inches wide, were then dissected up from the inner sides of the thighs; the bases adjoined the labia, and were left attached. A long pair of forceps were thrust down through the suprapubic opening, out between the labia, and the ends of the two skin-flaps grasped and drawn up through the newly-made vagina, the raw surfaces of the flaps lying against the sides of the vagina, leaving the two cutaneous surfaces to face each other to form the lining of the vagina,

and thus prevent destructive cicatricial contraction. The free ends of the flaps were stitched to the subcutaneous structures of the suprapubic wound, and the skin united over them.

The next step was to cover the areas left after dissecting up the flaps from the inner surfaces of the thighs. This was done by cutting freely under the skin on each side of the wound and sliding and suturing the skin of the denuded surfaces. The after-course was eventless. Although the operative area was necessarily very close to the bladder and urethra, there was no disturbance in urination—as might reasonably be expected. In ten days we began to insert plugs in the vagina, and in three weeks we severed the bases of the flaps which had been turned into the vagina. (Figs. 1 and 2.) She was given a rectal plug to insert occasionally till healing was complete. This was in March, 1901. In May her husband told me that the conjugal relations were perfectly satisfactory.

I saw her again in October, and although having other complaints—in no way related to her genital condition—she reported that there had been no dissatisfaction as to wifely incapacity.

Carl Beck reports a similar case.

CASE II. *An Unusually Pendulous Abdominal Wall.*—Mrs. —, æt. 45. Eight years ago she was under the treatment of a "Christian Science person." The latter had common sense enough, however, to advise that a physician be sent for when it became apparent that the patient was becoming dangerously ill. Upon examination I found slight evidences of sepsis, and outlined a hard tumor, about the size of a cocoanut, in the right iliac fossa. We operated, and the tumor proved to be a large fibroid of the right ovary, the centre of which was necrotic. The left ovary was cystic, and was removed. The patient was fairly stout at this time, and continued to grow more so. She tried in various ways to reduce her flesh, but was only temporarily successful. The accumulation of fat in the abdominal wall caused her great distress, overhanging the thighs and provoking chronic inguinal excoriation. Finally, it was decided that the only relief available was by means of an operation. (Fig. 3.)

Treatment.—The following operation was performed for the relief of the pendulous abdomen, and, incidentally, a ventral

hernia. The pendulous wall being raised from over the pubis and thighs, an incision was made from a point an inch and a half above the anterior superior spine of the ilium, sweeping downward and parallel with Poupart's ligament, crossing the median line just above the pubis, and up along Poupart's ligament to a point an inch and a half above the anterior superior spine of the ilium on the other side. The incision was carried

FIG. 1.



Showing mouth of vagina and base of one flap still uncut, scissors passed under it.
The scar of transverse suprapubic incision can be seen faintly.

down to the muscles and fascia, and the thick and enormous wall of fat was dissected well above the ventral hernia.

While investigating this, it was found that the recti muscles were widely separated well up to the umbilicus. So the wall of fat was raised, the sheaths of the recti muscles were split, and peritoneum, muscles and fascia coaptated with chromicized gut. Then the overhanging fatty wall was amputated and the upper margins drawn down over the hernial wound and stitched to the

skin across the trunk at the lower border of the original incision. It was the largest wound I ever saw. The incision was 27 inches in length, measured by a sterilized towel; this, in turn, measured by rule. The wall was dissected upward for 9 inches. It required 70 stitches to close the wound.

In ten days the stitches were all removed. Healing occurred without suppuration and without a stitch abscess, though some clear serum did collect in the wound on the right side. It was

FIG. 2.



Showing size of vagina ten days after operation.

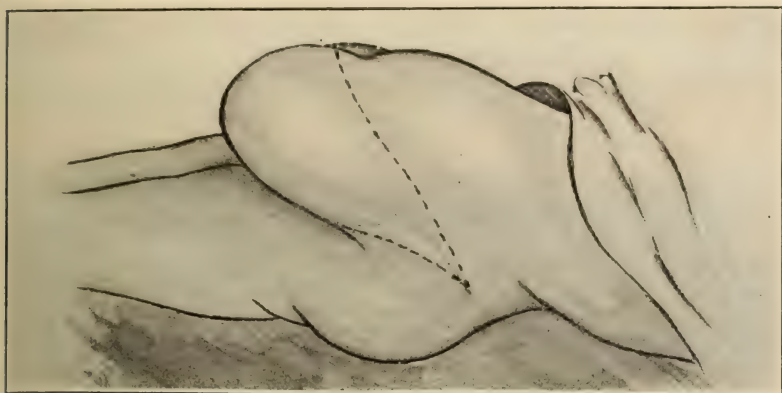
coaxed out between the stitches, and its presence was no surprise, considering that there were (estimating upper and lower surfaces) 400 square inches of raw surface.

The patient is entirely free from the distresses which led to the operation, and is very happy over the results. (Fig. 4.)

Comments.—I feel justified in recommending this operation for those who are suffering from ponderous, distressing and useless abdominal masses, which cannot be relieved by other methods. It is well known that these lipomatous abdominal

walls tend to separate the recti muscles, as well as other structures, and are therefore calculated to induce hernia. This provides another reason why these patients should be given

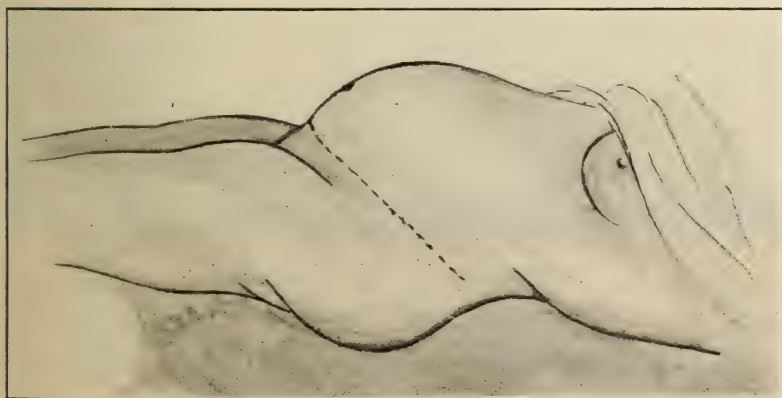
FIG. 3.



Lipomatous abdominal wall before operation. Dotted lines indicate incisions.

more study. I would call attention to the fact that the operation for the relief of a pendulous abdominal wall without hernia

FIG. 4.

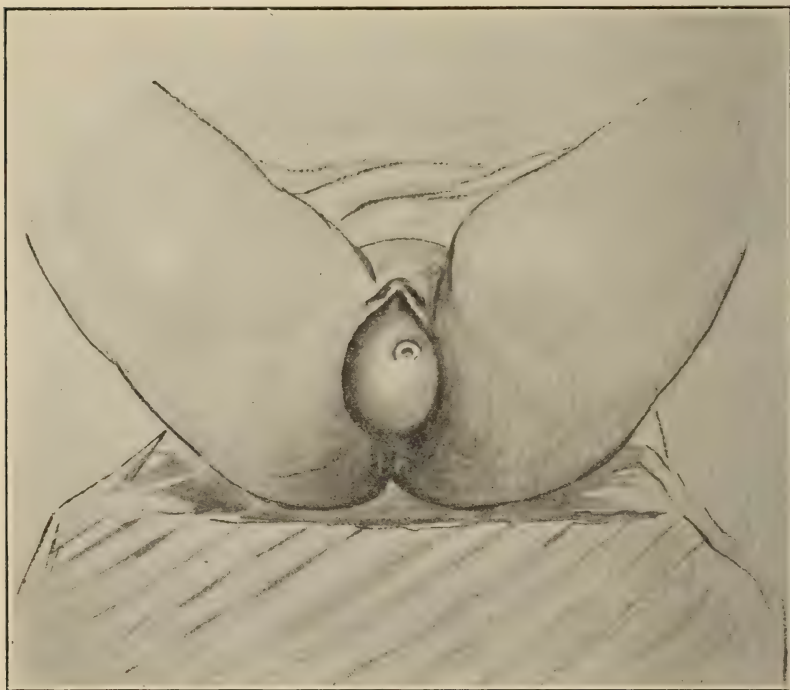


After operation ; dotted line indicates the present scar.

is much simpler than the operation described above, as more time was consumed in obliterating the hernial orifice than in extirpating the fatty wall.

CASE III. *Inveterate Procidentia*.—Mrs. —, æt. 60, had borne three children, and had suffered much from lacerated perineum, cystocele, rectocele, and, later, procidentia. For these conditions she had been operated twice with only trifling temporary relief. She had constant dragging and bearing-down pains in the abdomen and pelvis, frequent desire to urinate, and inability to do so satisfactorily. Defecation was difficult and distressing. She had sharp, colic-like pains in

FIG. 5.



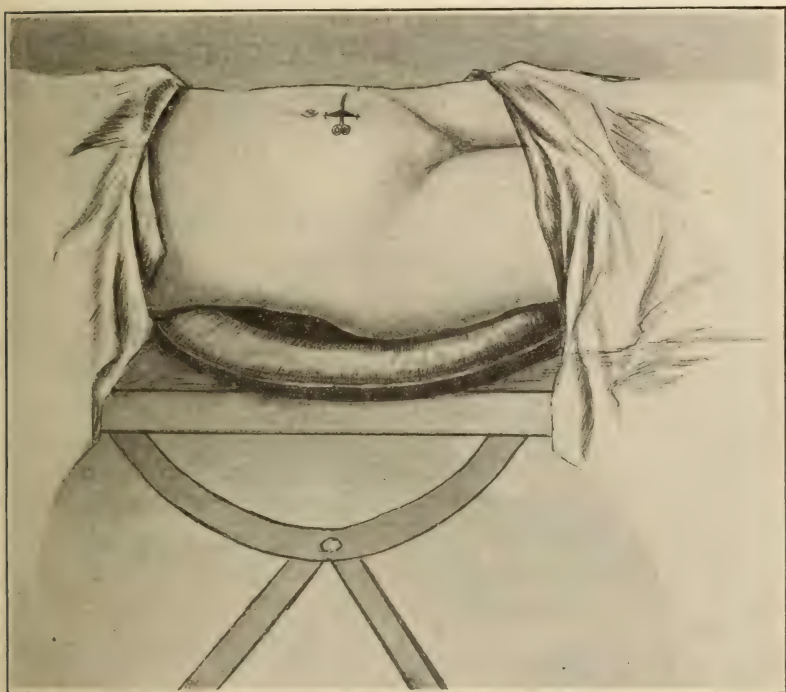
Hystero-recto-vesicoptosis before operation.

the abdomen. She had tried recumbency, pessaries, and various kinds of supporters, but was finally driven to operation for relief. (Fig. 5.)

Treatment.—The usual vaginal operations having been performed twice by competent surgeons and proven failures, it seemed to me it would be much simpler and surer to implant the uterus high in the abdominal wall, and thus obtain support for the relaxed pelvic floor, bladder, and the bowel. The patient

was therefore prepared for a cœliotomy in the usual way, and anaesthetized and placed in the lithotomy position. An incision $2\frac{1}{2}$ inches in length was made through the abdominal wall well up toward the umbilicus, exposing muscular structures. An assistant then grasped the cervix, and, by introducing the hand and forearm within the vagina, pushed the fundus upward and out through the abdominal wound. Here it was turned slightly, so that the broad ligament would not interfere

FIG. 6.



Scissors stitched to uterine fundus, acting as cross-bar to maintain uterus in place.

with snug coaptation of the fundus to the sides of the wound. The peritoneum was first stitched to the uterus, then muscles and fascia were united to the fundus by running chromicized sutures. The abdominal wall was very fat and thick; through this the uterine fundus extruded, and, to make absolutely sure that the patient's third operation would not be a failure, I laid a pair of scissors transversely over the wound and stitched it firmly to the fundus with silk. The ends of the scissors were

allowed to rest on thick gauze pads. (Fig. 6.) The operation required but twenty-five minutes, so that we could afford to give a little time to inspection of vagina. The bladder, bowel and vaginal vault were found drawn tautly upward, and a few minutes were devoted to the performance of an anterior and posterior colporrhaphy.

The after-course was symptomless. The scissors forming the cross-bar was cut away in three weeks, and the protruding fundus was cutified in a few days. She is very comfortable, and her relief is just what would be expected by the restoration of the pelvic organs to their proper positions. The cervix is drawn well up, and can just be reached with the finger, and the fundus can be plainly felt firmly imbedded in the abdominal wall.

Comments.—The production of adhesions between the fundus uteri and the parietal peritoneum just above the pubis for retroversion and prolapsus is familiar; but such a procedure would have been of but little service in this case, as bladder and bowels would still have protruded, such was the degree of relaxation. Shortening the round ligaments would have been useless; first, because this would not have raised the uterus high enough to take the slack out of the vaginal walls; and, second, because this means of support, even when combined with colporrhaphies, would not have been strong enough to sustain the weight of the protruding organs and overlying viscera, not to speak of the intra-abdominal pressure. Colporrhaphies would have been inadequate and only temporary. Le Fort's operation of closing the vagina is open to the same objection, also some others; and, what is equally important, neither of these operations would have taken the kinks out of the bladder and bowel, and drawn them into place.

Hysterectomy is so easy and tempting in such cases that the operator has to hold himself back. And, after all, the uterus is not to blame for the ptosis, and hence its removal without other operative steps will not be curative. Why not, then, preserve it to support the bladder and rectum; in a word, make it perform the function of a mesentery for the pelvic floor? True, it might be urged that the implantation of the uterus within the abdominal wall might lead to subsequent ventral hernia. This will scarcely be a very weighty objection in cases

like the above—old women who have at best but a few years to live, who can wear an abdominal support without trouble, and who are not subject to the straining and exertion which circumstances may have demanded in early life; and, finally, it is among women of advanced age that inveterate and intractable procidentia is usually found.

This is the fifth time I have operated in this way with perfect relief of the symptoms; and I once more call attention to this operation because not very long ago I read a very exhaustive article, written by a prominent surgeon, on the treatment of procidentia, and this method, which I regard as better than all the others, was not mentioned.

SMALL-POX AND VACCINATION IN ALASKA.

BY BERTRAND K. WILBUR, M.D.,

Late Surgeon to the Sitka Mission Hospital.

(Read before the A. R. Thomas Club.)

WHILE small-pox, within the last four years, has become a somewhat common disease, it is still, to many practitioners, one almost unknown by personal observation. Having recently passed through an epidemic in which the writer attended about 150 cases, some observations upon them and the effect of vaccination as a preventive or modifying agent will not, I trust, prove untimely. Observations of this nature seem the more needed, just now, as small-pox is still quite generally epidemic; and yet there is a widespread and growing opposition to vaccination, not only among the laity, but, alas! among not a few of the profession also.

The epidemic began in the early winter of 1900. An adult native walked into the office of the Sitka Mission Hospital, stating that he felt very well and strong, but with face, hands and body covered with a profuse eruption. The papules were hard, but positively not "*shotty*," and with no inflamed areola. The temperature, thrice taken, was normal. He said he had left a small town, 200 miles south of Sitka, five days previous, perfectly well. In two days he became very sick with chill

and fever, but on the third day the eruption appeared, and he felt better. He positively denied that there were any others similarly sick among the people he left—a statement subsequently shown to be a lie. He denied any venereal disease—also a lie.

Sanitary regulations are almost unknown there and less observed, and, to avoid quarantine restrictions, a number of towns with small-pox epidemic kept it well hidden; hence we had no knowledge of any epidemic in Alaska. This fact, together with the entire absence of subjective symptoms or fever, and the apparent well-being of the man, led to the diagnosis of chicken-pox. This seemed the more probable, as adult natives of Alaska frequently have varicella, numerous severe cases having been seen in the Sitka Hospital. Feeling sure of this diagnosis, the patient was not isolated but sent to the native village, where, a few days later, he was seen by the naval surgeon at Sitka, who diagnosed small-pox, the patient then being covered by a profuse pustular eruption, but still without fever, pain, or malaise. After a few days' observation, and securing a history of a primary sore a few months previous, the naval surgeon decided the case to be syphilis, with which diagnosis I agreed. The man had been isolated on a near-by island, and while still covered by the pustular eruption was stripped and photographed out of doors, though snow lay in patches.

In two weeks, however, all the occupants of the house to which this man had been sent, except one vaccinated girl, developed a similar eruption, and a panic ensued as new cases were attacked in various parts of the native village. At the same time a case occurred in the Mission Hospital, to be noted more fully later.

Ethics not being unduly pressed, the medical profession of Sitka was composed of Dr. H. B. Pitts, U. S. N., my warm friend, a capable man, a close observer and a hard student; a Russian priest with some medical knowledge, but with no regard for the code; an ex-naval apothecary of uncertain knowledge, and the writer. These gentlemen were unable to agree as to the true nature of the disease, the priest and the apothecary calling it small-pox, Dr. Pitts being unwilling to give an opinion, and the writer claiming it to be varicella. The natives, however, said it was "bad sick," and drove all

the afflicted to a near-by island, where, later, tents were erected and a rigid quarantine maintained. In a short time sixty people were isolated there, most of them in various stages of the disease. Rain and snow prevailed, the weather was raw and disagreeable, and the tents were on the wet ground for a week or more, until one of the missionaries bought lumber, and himself erected platforms and had the tents moved upon them. A number of cases on the island were of the partly confluent type, three or four entirely confluent, and in nearly all the eruption was very profuse. The only deaths were among those who were already much below par physically. Practically there were no deaths caused directly by small-pox.

About two weeks from the arrival of the first case in Sitka a woman was admitted to the Mission Hospital with symptoms of grippe, which was mildly epidemic at the time. This case presented general aching over body, but worse in the back; intense headache; temperature of 103° ; increased pulse, for which aconite and gelsem. combined were prescribed.

She had been sick one day; on the third day of the illness a very scattering eruption appeared, general over body, not shotty, no areola, and with the eruption all pain decreased and ceased. The eruption became vesicular on the fifth day, pustular on the seventh, and dried up with brown scales in ten days, leaving no pits. The diagnosis was again varicella, confirmed by Dr. Pitts. This case seemed almost a typical one of chicken-pox of mild type, but two weeks later every native who had been in the ward with the woman, including a number of girls from our Mission School, developed a similar but much more severe eruption. New cases began to appear rapidly among the 160 scholars in our Indian Training School. The infection was positively traced to this first woman, and from her to the school by the medium of the girls sent back to the school, unfortunately without disinfection.

Thirty-five cases were treated in our hospital wards, accurate temperature-charts kept, and symptoms noted. Some of the cases were the partly confluent type; one or two showed not more than 15 or 20 small pimples over the entire body. The general course was as follows: A chill, generally severe, followed by headache, marked backache, and temperature reaching 105.6° in one case, the average being 103° ; eruption ap-

pearing on inner wrists and forehead on 3d day, well developed by the 5th, vesicular on the 7th, pustular on the 9th, and drying, scabbing and exfoliating indefinitely until the end of the 3d week. Patients were discharged during the 4th week, after disinfection. Pitting generally present after healing. In one or two cases decided *crops* appeared, the eruption being found in all stages on the same patient at the same time. There is no doubt about this point, for especial pains was taken to observe this fact. The cases in which it appeared occurred during the worst of the epidemic, and occupied a ward with ten or a dozen others in whom the eruption ran a more typical course.

In every case subjective symptoms subsided as the eruptions appeared, and temperature fell slowly to normal, or nearly so, *i.e.*, within a half degree. But as the pustules formed the temperature rose slightly, rarely reaching 101°, and without any pain or ill feeling whatever. Indeed, after the eruption was fully established the cases all said they felt well, and were up and about the ward. Most often, always in the confluent cases, there was a sickening, horrible odor. In the hospital there were no deaths.

I have described these first cases at some length in order to emphasize the difficulty of diagnosis under some circumstances and in some epidemics. Certainly this was not the small-pox of the text-books. Reports began coming in from all over the States, through the medical journals, telling of exactly similar epidemics, but many doctors denied it to be small-pox. Fortunately, Dr. George Dean arrived in Sitka at the height of the epidemic, and having had a large experience with the same disease in the Cincinnati hospital, he pronounced it small-pox, and there was no longer any doubt as to its character.

And now as to the effect of vaccination on the epidemic. It might be expected that even though there was doubt as to the true character of the epidemic, vaccination would be practiced at once. But it must be remembered that we were 4000 miles from supply houses, and most of the supply in the town, not a very large stock at best, had passed the time limit and was unfit for use. Hence before fresh virus could be obtained the epidemic was at its worst, with absolutely no sign of decreasing, and a splendid field for rapid and virulent growth. Every

case, with the exception of one half-breed, was among the native race, the Khlingits. The peculiar, promiscuous life of the natives, their natural uncleanness, and the lack of means of applying any sanitary measures to their houses or bodies, presented the most favorable means for the increase of the epidemic.

With these conditions before us at the very height of the epidemic, vaccination was begun, and in about a week the whole settlement was vaccinated—about 2000 in all.

A decided decrease in the number of new cases was noticed at once, and in two weeks the epidemic was practically over.

A few cases, possibly five, came into the hospital wards after vaccination, with well-marked vaccine vesicles and the small-pox eruption, both present at the same time; but in each case the small-pox was milder, ran a more rapid course, and cleared up more speedily, so that the patients were able to be discharged in two weeks instead of four.

In passing, it is interesting to note that the writer, with two good scars, was re-vaccinated six times within three months, the sixth operation being the only successful one.

Glycerinized virus was used principally, and proved much better than the points.

At one time, the supply of virus being exhausted, scabs from three healthy girls were taken, macerated in glycerine, allowed to stand 24 hours in a cool place, and the clear fluid decanted and stored in a cool place for a week. This produced a virus which was very active and yet free from any germ-infection, producing a true vesicle, but, as far as results were reported, no abscesses.

In closing, allow me to call attention 1st, to the mildness of this disease, which even yet is denied the name of variola by some observers. It is most astonishing to see patients with very profuse papular, vesicular or pustular eruptions, with every other evidence of perfect health.

2d. The difficulty of diagnosis in the first cases, where there is no knowledge of an existing epidemic. While chicken-pox is very rare in adult whites, yet it can occur. The writer had varicella when 23 years old, and will testify to being a very sick man until the eruption was well established. But the extreme pain in the back is quite characteristic of variola in the early stages.

3d. Much stress has been laid on the "*shotty*" feel of the early variola eruption. We have failed to find it at all constant in the limited epidemic observed. But, as one examines the papules, it is thrust upon him that the *deeper* layers of the skin are involved, not merely the superficial ones.

4th. That vaccination, unaided by house or personal sanitation, stamped out the disease, and stopped the epidemic promptly.

5th. That vaccination very greatly reduced the severity of the disease in the few cases not rendered immune.

6th. That vaccination conferred immunity on all whites and 95 per cent. of natives in the Sitka epidemic.

7th. That among more than 400 vaccinated by the writer, and observed for six months subsequently, swelling of the arm, rarely of the hand, and sub-axillary glands, were the most serious sequellæ seen. *There was not one abscess.*

These observations add another strong proof of the efficacy of vaccination, and show that with proper care, a care that cannot be too rigid in shutting out all possible infection, bad results from vaccination ought to be and are absolutely unknown.

WHEN IS THE LAW OF SIMILARS INDICATED?

BY M. W. VANDENBURG, M.D., MT. VERNON, N. Y.

"BUT the stupid disciple of Æsculapius did not know that the law of similars was not indicated."

Perhaps the stupid disciple of Æsculapius did not know that there are several other laws or methods of cure beside the method of similia.

Had he sufficiently pondered the subject, he might have avoided several errors which he may have long cherished. But his name is legion. First, there is the law of mechanical cure; or, as it may be better styled, the *method* of mechanical cure. This embraces all operative surgery; all clearing of the various tracts from blockades, whether accomplished by drugs or other means. The relieving of a waterlogged system, whether by the bowels, or the kidneys, or the skin, or all three com-

bined, is an application of this method. So, too, is the stimulating of heart-action that the heart may keep up with its work.

The repair of the tissues is another question. That depends on a deeper law or principle—the principle whereby any sick organism tends to return to health. This has been recognized from time immemorial, and has been most fitly styled the healing-power of nature—*vis medicatrix nature*. This is the fundamental force in all curative processes, without which all efforts are vain. The measure of its strength is the measure of the possibility of a return to health. Alone it will often effect a return; properly assisted, the return will be much more speedy and safe.

There is a third method of cure, often known as massage, or the movement-cure, and by other similar terms. This is a branch very closely related to mechanical methods, and need only be mentioned here as being applicable in a limited number of cases.

A fourth method has long been known as the method by revulsion. Its main instruments are the application of heat or of cold, or of both in alternation. This method may be applied in the form of dry heat or dry cold, moist heat or cold, as in baths, packs, sponges, ice-applications, and similar measures; or the revulsives may be cauteries, or blisters, or setons. In certain cases and conditions these methods have a curative value. Electricity is another means of cure in a limited number of cases.

Hygienic measures, which have to do with environment in the broadest sense, are frequently all the measures needed to cure certain sicknesses. In all cases these measures are indispensable in a greater or less degree when using other methods of cure; but they may be considered a method of cure by themselves.

Finally, there is a method of cure which administers poisons of greater or less intensity for the purpose of effecting a cure.

The administration of acidulated quinine hypodermically belongs to this method. To disprove that the law of similars has not been called into use in such a case, it is necessary to show that the same procedure upon the healthy would not produce a similar disease to the one it has cured. Until that has been

shown, we shall be obliged to defer judgment, but with a strong inclination to credit the cure to similars.

All allopathic, or so-called scientific *materia medica*, that gives the "physiological action of the drug" with any adequate degree of completeness, and also gives "its curative action," is a monument to similia. Even its contra-indications are a proof of the same method of cure; for it will invariably be found that contra-indications in drugs simply mean make the doses small, or very minute, in all those cases where a similar state is produced by the drug in its physiological action. Acute gastritis in arsenic is a good example.

As to mercury and syphilis, only a superficial study of the physiological action in allopathic books is necessary to convince one that it is a most notable case of the law or method of similars. So, too, of iodide of potash. It remains for anyone who claims a different curative method for the action of these or any other drugs to produce the example. Drugs for their mechanical effects; drugs for their revulsive effects, which is quasi-mechanical and quasi-derivative (one blister is usually as good as another, for curative purposes); drugs for dietetic effects (supplying normal elements to help on the digestive process)—all these uses are *not* according to the law of similars.

In some of these cases the law of similars might have been a better, safer and more convenient method of cure, but in a number it is wholly inapplicable.

As the case now stands, the burden of proof lies with those who claim exceptions to the general rule.

We often hear physicians speak of "the curative drug." When there is only one known drug that produces an effect similar to the disease, we may so speak; when there are two or more that produce closely similar physiological effects, either will be beneficial.

If a drug, by virtue of its toxic qualities, produces a curative effect that is not mechanical *per se*, or derivative in a fair sense of the term (counter-irritant), or dietetic—if it relieves pain or sickness by direct action upon the vital processes, by stimulating the reparative forces, it may fairly be inferred that it acts according to the law of similars. Especially may we suspect this the case in toxic diseases, or diseases that depend on toxic infections. The dose is not a material consideration; the cure is.

THE EARLY DIAGNOSIS OF PULMONARY TUBERCULOSIS.

BY FRITZ C. ASKENSTEDT, M.D., LOUISVILLE, KY.

SINCE the discovery, in 1884, of the tubercular bacillus as the specific cause of pulmonary tuberculosis, its symptomatology has acquired a more extended and definite form. The failure in the days gone by to properly recognize this disease before the formation of cavities, the advent of hectic fever, emaciation, etc., indicating a secondary infection—a veritable septicæmia—is responsible for the gloomy outlook so generally attached to pulmonary consumption, and the apparent indifference with which the profession saw one-seventh of mankind succumb to its ravages. A closer study, during the past decade, of the incipency of the disease has revealed not only that pulmonary tuberculosis can often be recognized before such common symptoms as cough, fever and rapid pulse have developed, but also that in this stage the disease is readily amenable to appropriate hygienic treatment. It is possible, therefore, to detect a group of symptoms pointing definitely to tuberculosis, even before the appearance of the bacilli in the sputum, which are in evidence only after the lung tissue has begun to break down. Such a group of symptoms will, however, present considerable variations in different patients, rendering an early diagnosis a matter of practical experience, acuteness of observation and nicety of judgment, as well as of technical knowledge.

The symptoms of tubercular predisposition merge so gradually into those of the *début* of the disease that the following rule for estimating the deficiency of chest measure and weight may not be out of place: The chest measure, midway between inspiration and expiration, is, in health, no less than one-half the height, while the weight is never less in pounds than the height in feet, multiplied by 26 in men or 23 in women. That emaciation is not a constant symptom, however, is shown by Lænnec, Franck, Cornil and Hanot, who report cases with advanced pulmonary lesions while the patients presented an appearance of good health and plumpness. A case recovering from the

second stage of pulmonary tuberculosis in a patient that was actually obese was seen by me last year in Prof. Edgren's clinic in Stockholm.

Mentally, the patient in the incipient stage exhibits an exuberance and buoyancy not before noted, his memory and reason become sharpened, and his intellectual activities are increased; but this will soon give place to intervals of depression, to irritability of temper, to periods of despondency, and, as the physical strength becomes undermined, to general lassitude of intelligence.

Gastric irritability, as manifested by fullness and distention after eating, pyrosis, anorexia, and an especial distaste for fats, is frequently among the earlier symptoms of phthisis.

Anæmia, associated with leucocytosis, is an almost constant clinical sign, and is due to a reduction in hæmoglobin rather than a diminution of the red cells.

A distinct reddish line is occasionally seen on the gums, contrasting against the pallid hue of the mucous membrane of the mouth.

The eyes often show a peculiar bright or glistening appearance, while the pupil on the side of the affected lung is sometimes found dilated.

Elevation of temperature after meals or moderate exercise, and before menses, is an early symptom, and of especial significance is a *subnormal* temperature in the evening.

Night-sweats may occur occasionally in the early stage of tuberculosis.

The typical cough is at first dry and irritating, coming on after retiring at night, and, later, annoying the patient also on rising in the morning. As the disease progresses it becomes more frequent and loose, and is accompanied occasionally with nausea and even vomiting, and provokes an expectoration of a yellowish, sometimes blood-stained, sputum containing tubercular bacilli.

Hemoptysis is, at times, the first symptom calling the attention of the patient to his illness.

Rapid pulse has long been a recognized symptom of incipient phthisis, but is so frequently absent in this stage, and so generally a result of other disturbances of health, as to be excluded by many phthisiographers.

Thoracic pains are of frequent occurrence, and, according to Roussel, even before consolidation can be detected by ordinary means the patient may experience hypersensitiveness to unequal percussion—*i.e.*, striking only the nail of the finger percussed with the percussing finger—over the infiltrated area. At the same time an increased reflex action may be observed in the pectoralis major on the affected side, gradually diminishing as the muscle wastes.

Atrophy of some part of the scapulo-thoracic muscles will be noted by an increased depth of the supra and infraclavicular depressions of the same side as the diseased lung, or a marked flatness in the scapular region as compared to that of the opposite side.

Placing the palmar surfaces of the hands symmetrically over the chest, one can often feel, while the patient takes a forcible inspiration, the diminished expansion of the affected lung. By applying the more sensitive ulnar surface of each hand alternately over the two lungs, the area of consolidation can usually be recognized by an increased vocal fremitus; it should be borne in mind that the normal fremitus of the right apex is somewhat greater than that of the left. Vocal resonance is so intimately associated with vocal fremitus as to be found *pari passu* with it.

Careful percussion will often reveal consolidations before the patient has complained of a cough. The patient being stripped to the waist, the percussion should extend symmetrically over the whole chest, including the apices in the supraclavicular regions, both before and after forced inspiration, and due attention should be given the apices of the lower lobes in the intrascapular region. Digital percussion offers the advantage over the use of the pleximeter in revealing the greater amount of resistance of underlying consolidations, and only one finger of each hand should be used.

A diminished vesicular murmur, with a certain amount of roughness on inspiration, persisting near the apex, strongly points to tuberculosis, even before dullness can be elicited. Cogwheel breathing is frequently observed, but is too often present in other, even normal, conditions to prove of much value. Prolonged expiration and bronchial breathing will be noticed in advanced cases. Crepitant *râles* may sometimes be

heard over apex and, at times, only at the base of the affected lung.

The use of tuberculin for diagnostic purposes is still resorted to by a number of clinicians, although experience has proven that the reaction can hardly be considered specific. It has been obtained in leprosy, syphilis, actinomycosis, chlorosis, and cancer—according to Netter's observation, in as large a number as 27 per cent. of non-tuberculous cases—and time and again it has given negative results where the patients have presented bacilli tuberculosis in their sputum. Whatever of value there remains for tuberculin as a diagnostic agent for our patients is offset by the danger of disseminating tubercular germs from the foci of infection through the process of the local vascular stimulation induced. For the same reason, the rapid degeneration and congestion of the tissue with the production of moist *râles*, consequent upon the administration of potass. iodide, should discourage the employment of this drug as a diagnostic measure.

While the relative value of these symptoms can receive a proper estimate only from clinical experience, and while the association of symptoms may vary greatly in different cases of incipient phthisis, yet a mental picture of a typical case presenting all the above manifestations will aid us greatly in searching for and discovering a complex of symptoms that would warrant a positive diagnosis. Of course, many cases, in the *début* of the disease, may still remain obscure, and it will then be necessary to re-examine the patient at intervals of a few weeks, to determine the permanence of the signs elicited and the development of corroborative symptoms, until satisfactory evidence is obtained.

HEMIANOPSIA IN ECLAMPSIA.—(Knapp.)—The patient was a primipara delivered during coma by dilatation of the cervix, version and extraction. The patient complained, when consciousness returned, that the right field of vision was limited up to the median line, and the hand could be distinguished in it only as a thick cloud. The symptom disappeared on the next day. Pick considered it due to atoxic paralysis of the central visual tracts, with marked involvement of a hemisphere. This opinion is supported by the half-sided motor disturbances in uræmia.—*Prager Med. Wochenschrift*, No. 21, 1901.

VARIOLA—IS IT PREVENTABLE—IS IT CURABLE?

BY C. S. MIDDLETON, M.D., PHILADELPHIA.

(Read before the Hahnemann Club, January 14, 1902.)

THIS paper is not intended to be exhaustive, but merely to be a recital of certain features and facts, especially as to treatment. The continuance of small-pox in our midst makes any reference to this disease from a medical standpoint a matter of interest, even though it may seem as if the subject had been worn quite threadbare.

The propagation of small-pox is so well understood by all intelligent persons that it would seem quite unnecessary to say that it is through contagion, both by absolute contact with cases, or by infected articles. The pathology is that of zymosis, its complications many—notably renal—and whose germ has not yet been defined, so far as I know.

The history goes back to many centuries ago, the disease “having been imported into Europe from Asia, where it had been known and recognized from a remote antiquity.” The earliest accounts of its existence reach back to the middle and end of the sixth century, when it was described by Procopius and Gregory of Tours as “occurring in epidemic form in Arabia, Egypt, and the south of Europe.” Even at this early day variola was clearly described, its pathology explained by a “humoral or fermentation theory. . . .”*

It is quite unnecessary to enter into a dissertation on the symptoms and various phases of small-pox, as text-books abundantly supply this information. It might be well, however, to call attention to some of the complications with which certain cases are associated; and, aside from the various complications of the chest,—bronchitis, pleurisy, pneumonia,—diphtheritic complications of the throat, ulcerations of the eyes, ears, etc., occur, and probably most serious all is the renal, or nephritis.

* Rhazes, vol. xv., p. 805.

"A study of the urine of 1400 cases of small-pox showed that albumin should be considered an almost constant accompaniment. Positive reactions were obtained in 95 per cent. of the cases, and in 32 per cent. abundant quantities were present. The maximum amount corresponded in general to the early febrile period. . . . Albumin persisted in 75 out of 100 cases in small amounts, even during convalescence. . . . It is believed that the albuminuria of small-pox is not simply functional, but due to an alteration of the renal tissue."* This will apparently explain the cause of the death of many cases wherein the formation of pus, and consequent secondary fever, would seem not to be of sufficient gravity to end the patient's life. Recognizing the many disgusting features of this disease, the exceedingly high rate of mortality where no measures are brought to prevent or to cure it, the mind of the enlightened, both of the laity and the profession, turned to the thought of how to prevent the spread of small-pox, and eventually inoculation with the virus from the matured pustules came into vogue, "introduced into Europe by Lady Montagu, in 1718."

This practice, when associated with proper hygienic measures, although attended with considerable mortality, yet eventually lessened to a very great extent the material for other epidemics in the future to feed upon, thus proving that it was possible to prevent the well-nigh universal prevalence of small-pox. But it remained for Dr. Edward Jenner, of Gloucestershire, England, to proclaim and utilize, in 1798, a much more benign process for preventing or modifying this terrible disease, that of vaccination with virus from cow-pox,—a rare disease of the cow, similar in its pathology to that of variola in man, with the facts of which you are all familiar.

This preventive measure was introduced into this country by Dr. Benjamin Waterhouse, of Boston, Mass., in 1799.

"In 1866 a case of genuine cow-pox was discovered at Beaugency, France: . . . the fresh virus was secured and multiplied by vaccinating from one heifer to another, for the purpose of producing virus for general use."

It was from this source that Dr. Henry A. Martin, of Boston, Mass., originated his vaccine farm, which has supplied

* Francois Arnaud, *Revue de Med.*, May 10, 1898.

many of us with a reliable product these many years, thereby enabling us to abandon the use of humanized virus, with its many risks of transmitting constitutional diseases with which the human family are too often afflicted.

Without going into details, the superabundance of evidence from various countries, notably that of Germany, where compulsory vaccination clearly proved—and at no time more abundantly than the comparative results between her soldiers and those of the French during the Franco-German war—that small-pox is practically a preventable disease, limited only by a greater or lesser use of the means at our command, namely, vaccination, and re-vaccination.

Compulsory vaccination reduced the loss of the German nation by small-pox from 143,000 in 1871 to but 116 per annum after the law of 1874. Even before this law was passed, the German government ordered compulsory vaccination of all her soldiers, and during the Franco-German war both armies were attacked. The French, who were lax in this regard, lost 23,000 by small-pox, while the Germans lost but 278; and in the same tent, where the wounded of both armies lay, the French were heavily attacked, while the Germans had not a single case. (Bezzozero, *Med. News*, Dec. 17, 1898.)—Sajous, *Ann.*, p. 806.

Those physicians who have had an experience of many years, which has been likely to have carried them through an epidemic of variola, will, I believe, bear testimony to this effect.

Now as to the *curability* of small-pox. Because a patient recovers from an attack, that alone is no evidence that he was *cured*. It is just possible that many who do not know why will nevertheless break into an audible smile when the writer asserts that small-pox is *curable*!

In a short article on small-pox by the writer, published in the HAHNEMANNIAN MONTHLY, April, 1872, it is asserted that the administration of carbolic acid internally will so modify this disease that, given immediately after the eruption has appeared, the course is cut short, the pustules dry up without suppuration, and the secondary or suppurative fever is completely prevented. In this article a series of 4 cases are given as a proof of the statement.

I had treated about 35 cases in that epidemic up to that time; subsequent additions to the above number ran the ag-

gregate up to 56 in all, and the continued use of carbolic acid substantiated the report of the results in the other cases.

Carbolic acid 1x* was used, about ten drops in half a glass of water, and a teaspoonful given at intervals of two hours. (I would not hesitate to give it as often as one hour intervals in the most urgent cases.) In that article it was stated that the remedy was not used until the eruption was fully established, and even then secondary or eruptive fever was entirely prevented.

That is correct, and I thought at that time it was the safer course. I still believe it sufficient to prevent secondary fever and pitting, but I am just as firmly convinced that if we could be *positively* assured that we have a case of small-pox to deal with in the beginning of the first stage, before the eruption has appeared, *we can prevent the eruption even, and thus CURE the disease in toto*, and thus save much valuable time and suffering, ignoring, if you will, the unsightly pitting, and go still further in our beneficence by preventing the spread of the disease.

Should it fall to my lot to have any cases amongst my patients, and I can be positively certain that I have variola to deal with, I shall, reasoning *a priori*, prescribe carbolic acid at once, fully believing the truth of the last assertion, as of the first, will be realized.

One difficulty must be noted, that in all cases resembling small-pox, where carbolic acid shall have been used, and where no eruption shall have appeared, doubt will at once be thrown upon the diagnosis. Now, whether this medicament be homœopathic to small-pox or not, it will *cure*, by destroying the germ within the blood, if used as above; I would have no faith in the drug in the extreme high potency. *But* if one will examine the *Materia Medica*, one will find abundant evidence of the similarity of the symptoms of carbolic acid to those of small-pox, especially to those of the skin, setting aside any reference we may feel applies to its effect on the organization of the blood.

The writer has had volunteered testimony to the value of

* Upon investigation, I find the above strength equivalent to the tincture of the present Pharmacopœia.

this remedy as related, but it is his desire that homœopathic physicians especially shall reap the advantage of its use, thus not only adding to their popularity, but also that more of the unfortunate may be relieved and retain their cosmetic perfection.

DIAGNOSIS AND TREATMENT OF PULMONARY ABSCESS.

BY F. MORTIMER LAWRENCE, M.D., PHILADELPHIA.

(Concluding Remarks at a Medical Conference held at the Hahnemann Hospital, Philadelphia, December 18, 1901.)

THIS case presents several features of unusual interest. The patient, a young Englishman, aged twenty-one years, tells us that up to last winter his health had been perfect. A little over a year ago he went to Zanzibar, Africa, in the capacity of a ship's steward, and after five months' residence in that climate he was seized with fever and ague. The chill occurred daily about 11 A.M., lasted about an hour, and was followed by an intense fever, which lasted for several hours, and terminated in a drenching sweat, which brought relief. After three or four such paroxysms he seemed to recover, but in the course of a month he relapsed; and, in fact, in spite of repeated apparent recoveries, the paroxysms of chill and fever reappeared for a few days during each of the four months during which he remained in Zanzibar. Then he went to Arabia, and was forced to enter a hospital there for three weeks, because of a recurrence of the attacks. In the course of his return voyage by boat to England two or three more paroxysms occurred, but after that the ague left him, and his health became as good as ever.

Six weeks ago he came to America. A little over two weeks ago, on a Saturday night, he became chilled while at work. He went home and to bed, had a severe rigor, which lasted for an hour or more, and this was followed by high fever, intense thirst, epistaxis, cough and dyspnœa, with a sensation, he says, as if somebody were sitting on his chest. He was confined to his bed for ten days, and then, feeling a little better, got up and came to the Hahnemann Hospital Dispensary. Our exami-

nation revealed diffuse dullness over the base of the right lung posteriorly, with weak breath sounds and diminished vocal resonance, and harsh breathing over the entire lung anteriorly. There were numerous moist râles; he was expectorating freely a blood-streaked muco-purulent sputum, and his temperature was 101.8° F. He was put to bed in the hospital at once, and his history from that time on is revealed by the chart. The record of his temperature shows the widest variations; often in the course of a single day it has ranged from 98° to 103°, and its rise and fall has been utterly without reference to the time of day. His respirations have varied from 20 to 28, and his pulse from 80 to 100. His expectoration has been remarkably profuse, still muco-purulent and blood-stained; and, in addition, two nights ago he suddenly coughed up six ounces of thick, greenish pus, mixed with a little blood. He has been sweating profusely each night, is emaciating rapidly, and, as we glance at him, we can see the hot red flush over his cheeks which we have been wont to describe as hectic. His lips are dry and parched, his tongue exhibits a whitish coating, and his breath is very offensive. His condition, as you can see, is a serious one.

In order to arrive at a diagnosis in this, as in all cases, it is well that we should glance back to the very first symptoms of ill-health of which the patient gives a history—in other words, to the fever and ague with which he suffered a year ago. You all know the skepticism with which I regard a diagnosis of malaria based upon these symptoms alone. I have told you that a majority of the cases of chills and fever in this climate ultimately prove to be tuberculous. But I must confess that in the present instance I can find no valid reason for refusing to accept a diagnosis of malaria. Here we have a patient who was residing in a notoriously malarial district, in whom the rather typical paroxysms were repeatedly controlled, presumably by the use of large doses of quinine, and in whom every trace of the disease disappeared when at last he reached a non-malarious region. Under the circumstances we are justified. I think, in assuming that our patient did have a true malarial fever, probably a double tertian, and that his recovery was quite as complete as he assures us it was.

Having by this assumption excluded any direct relationship

on the part of his previous malady to his present illness, let us further interpret the history which he gives us. Two weeks ago he was seized with a chill, which was followed by high fever, severe dyspnoea and cough. After ten days of rather severe suffering he began to feel a little better, and so got up and came to the hospital; and at that time we were able to discover well-marked consolidation of the lower lobe of the right lung. We could scarcely ask for a clearer or more typical picture of an attack of lobar pneumonia. To be sure, with our suspicions as to the possible origin of his previous chills and fevers we might be justified in regarding this as the result of infection with the tubercle bacillus rather than the pneumococcus; or, in other words, our patient might be the victim of pneumonic phthisis. The latter, however, is far more apt to affect the apex than the base of the lung. It rarely leads to the consolidation of a lobe *en masse*; it is apt to be lobular rather than lobar. Moreover, his sputum has been examined repeatedly and with the greatest care, and our painstaking search has not revealed the tubercle bacillus.

How, then, shall we interpret our patient's persistent fever and lung solidification? For a few days there might have remained considerable question as to our diagnosis. We might, perhaps, have clung to the idea that there was simply an unresolved pneumonia. But a temperature range such as he has exhibited, ranging back and forth between 98° and 103° in the course of a single day, usually means but one process—suppuration. Confirmatory evidence as to the existence of that process was found, too, in his leucocyte-count of 17,000. Such a well-marked leucocytosis is practically never seen in tuberculosis, which usually affords, instead, a decided diminution—a leucopenia. This leucocyte-count would also seem somewhat excessive at this stage of an uncomplicated pneumonia.

All doubt as to the nature of our patient's symptoms were removed, at any rate, when, two nights ago, he suddenly coughed up more than a cupful—six ounces—of pure pus. This gave us, for interpretation, two symptoms which are of themselves almost pathognomonic, viz. :

1. A fever of septic type.
2. The sudden expectoration of pus in large quantity.

Practically, these symptoms can mean only one of two con-

ditions: an abscess of the lung itself,—in this case consecutive to a pneumonia,—or the discharge of an abscess into the chest from the abdomen or pleural cavity. The latter, an empyema, would presumably have been preceded by the symptoms of a pleurisy rather than a pneumonia; and, in addition, its discharge in this manner would give rise to a pneumo-thorax, the characteristic physical signs of which, such as the “bell-note,” the “falling-drop sound,” and the “metallic tinkle,” are absent. So we can almost certainly exclude empyema. Abscess of the liver or subphrenic abscess, penetrating the diaphragm and discharging through the lung, might, of course, present symptoms similar to these. But in such a case there would probably have been not one, but many rigors, the patient would hardly have expectorated so freely for the two weeks preceding the rupture of the abscess, the general symptoms would not have been as typical of pneumonia in other respects, and the pus coming from the liver would have been apt to be of a dirty brown or chocolate color. The utter absence of physical signs about the liver permits me to feel positive that any sub-diaphragmatic lesion can be excluded, and we are justified in a positive diagnosis of abscess of the lung.

Suppuration is, as you know, a somewhat rare termination of the pneumonic process, occurring in less than two per cent. of the cases. Instead of the gradual disappearance of the fibrinous exudate which constitutes the stage of resolution, a portion of the consolidated lung, varying in size from that of a pea to an entire lobe, becomes infiltrated with pus-cells, which fill not only the alveoli, but the interalveolar walls. If this abscess is small, it may become encapsulated and undergo resolution; but if it is of any size, and the patient survives long enough, it is discharged through a bronchus. This is what has happened in the case before us. It is often possible, under the circumstances, to demonstrate the cavity formed by the destruction and removal of such a considerable area as must have been involved, but in the present case most careful examinations have failed to do this. We can take comfort, however, in the fact that pulmonary cavities are more often discussed than demonstrated, even in cases in which there is every reason, *a priori*, to suspect their existence.

As you can readily understand, pulmonary abscess consti-

tutes a very serious complication—indeed, recovery is the exception rather than the rule. That it does occur, however, is the testimony of many of our most acute observers; and that knowledge should insure for our patient the most interested care. During the period which precedes evacuation of the abscess, indications may be observed for a variety of remedies, especially those, such as hepar and silicea, that are distinctly applicable to septic conditions. Our patient has been receiving silicea for several days. That remedy is very useful in the septic states which attend softening and excavation in pulmonary tuberculosis, and, by analogy, should prove effective in a similar process complicating pneumonia. Another remedy in which I have great faith is the arsenite of quinine. Quinine has been extensively used by the old school for suppurative processes, often under a supposition that the case was malarial, and has shown a rather remarkable ability to control, though, unfortunately, not to remove, those conditions. In addition to appropriate internal medication, our patient should receive a full allowance of easily assimilable food, in order to meet the fearful drain upon his system; and alcoholics are often desirable. Our patient is at present being nourished and supported by milk punches. As soon as the discharge of pus has occurred, or even earlier, if there is much expectoration, antiseptic inhalations, such as are used in pulmonary tuberculosis, are advisable. I prefer the mixture of equal parts of alcohol, chloroform, and beechwood creosote, of which twenty drops is placed on the sponge of a Yeo, or, better, a Goodno respirator, for every twenty minutes of inhalation. In a case of this sort the use of the inhalant may be practically continuous; to a certain, perhaps limited, extent, the lung tissue is rendered aseptic, and, at any rate, expectoration is greatly stimulated.

In certain selected cases, in which the abscess can be demonstrated in an accessible portion of the lung, evacuation and drainage by surgical means might be considered. I have, however, no personal experience in the matter, and so leave the discussion to our surgical confrères.

EDITORIAL.

THE TRAINED NURSE.

THERE still exists in the minds of some of the laity, and even of some of the profession, a prejudice against the "trained nurse," but she has come to stay. The passing away of the Sairey Gamp type of nurse was a natural and necessary consequence of a clearer insight into the power of nature to restore to health a large percentage of cases without the intervention of physician or drugs, provided she were given rational, well-directed assistance by competent nursing. The gradual evolution of the "trained nurse" is an interesting process to watch, and the resultant product is one not only of interest, but of the highest importance to the physician.

The danger of the nurse's supplanting the physician in the confidence of the patient and his friends was early recognized and guarded against by those who originated the training-schools for nurses, so that at present it is only in exceptional cases that unpleasant complications arise; indeed, mutually pleasant complications are of more frequent occurrence. The position of the medical attendants toward the nurse is recognized as that of a superior officer, whose requirements and instructions are to be implicitly followed. Whether the nurse will prove willing and able to render a cheerful and ready obedience will depend largely upon the character of the instruction she has received in the school in which she has been trained. It seems, therefore, not only obvious, but rational, that the general plan and scope of their instruction should be determined, not by any theoretical abstruse principles, but by the practical wants and demands of physicians,—those who are expected to employ them. We will venture, therefore, to specify some of the points to which, we think, particular attention should be paid in the training of a nurse.

First catch your nurse. A nurse, like a poet, is born, not

made. The greatest care should be exercised, without fear or favor, in accepting candidates for this important course. Simple good health, willing hands and fair education are not enough to insure the turning out of a good nurse. There is, in the first place, an undefinable something, which we may call sympathetic disposition, which can, under circumstances, make a good nurse of an ignorant person, and the absence of which cannot be compensated for by the most thorough instruction in the duties of a nurse. Where we find this quality combined with thorough training we have an ideal nurse. We do not mean a weak, sentimental sympathy, than which nothing can be more detrimental to good work on the part of a nurse, but a quality which expresses itself, not in words, but in the manner of performing even the least office for the patient—a certain something which enables its possessor to do everything for the patient as if from the promptings of good-will and sympathy, and not from measured, mercenary motives. The sick are generally hypersensitive, and are very ready to feel a perfunctory performance of duty. This quality furnishes an iron hand in a glove of silk.

But there is another quality which, although usually found in one of a sympathetic nature, may exist without it, and if not present at first may to a certain extent be cultivated and developed, and which must be if a nurse is to be able to fulfill her duties to patient, family and physician. We mean tact, which is defined as “intuitive sense of what is true, right, or proper; fineness of discernment as to action or conduct, especially a fine sense of how to avoid giving offence; ability to do or say what is best for the intended effect.” According to the old adage, it is impossible to “make a silk purse out of a sow’s ear,” and there are some poor unfortunates in whom this quality is neither present by nature nor capable of being developed. They are like the proverbial bull in the china shop. Where this condition becomes evident after due trial, its possessor should be incontinently rejected, no matter how proficient in other respects she may prove herself to be. A nurse without tact becomes a source of danger and discomfort to all around. She is a thorn in the flesh to the directress of nurses and her fellow-students before graduation, and when she begins to practice her profession becomes a gadfly to her patients and a

stick of dynamite to the attending physician. There are, fortunately, few who cannot be taught to have a measure of tact capable of being cultivated, provided its necessity is recognized by the instructors and sufficiently insisted upon. Many of the candidates come to the training-school from environments where bluntness and want of tact are held to be synonymous with honesty and truthfulness. These need only to have the true meaning of tact and its importance explained to them, and the faculty, essentially a feminine one, is found to have merely been dormant, and capable of being readily aroused.

Other essential qualities of a nurse are quickness of comprehension and presence of mind. These will depend in a great measure upon the extent and thoroughness of the knowledge possessed, although temperament and mental development have also much to do with them.

General deftness and manual dexterity are required. The fingers dare not all be thumbs. These qualities are to be cultivated and developed not only in the line of making bandages and applying dressings, but also in the making of beds, arranging pillows, shifting patients, etc. To the patient nothing is insignificant which in any way affects his comfort, and everything should be studied with that aim in view. The preparation of the food for the patient we regard as a very important part of the duties of the nurse. We mean not only the cooking of the food, but also the manner in which it is presented to the patient. This is a point which is but too often neglected. It is of almost as much importance to have our meals served in a tasty, appetizing way, as it is to have them well cooked. How we eat often means as much as what we eat. Not only should the nurse know how to serve the meals so as to tempt the sluggish appetite, but she should be well grounded in the art of cooking. In many places where her services may be required her presence in the kitchen would be resented—in some, because a greater than she is there, in the person of a *chef*; in others, because of the fear lest she cause trouble by her dissatisfaction with existing conditions, or by her usurpation of too much authority. In spite of this, there will always be plenty of occasions on which she will be able to practice her art, and she should therefore be able to cook, and to cook well, the various dishes required in the dietary of a patient. There is

cooking and cooking, and it needs but a little experience with the brews and concoctions elaborated by the self-made nurses who swarm around the sick-bed in the country, to be impressed with the great advantage to patient, and thus indirectly to doctor, derived from the ministrations of a nurse skilled in the culinary art. The shortest road to a man's heart lies through his stomach.

Add to these thus hastily sketched requirements a healthy body, a cheerful mind, a clean soul, and neat habits, and we have "an aggregation of attractions" (as the posters would proclaim) which cannot fail to overcome all prejudice, and bring comfort and cheer into the sick-room.

But where is all this to be acquired? Where and by whom is this paragon of perfection to be fashioned? In the training-schools. Of what paramount importance is, then, the regulation of these. How vital becomes the question as to the qualifications of the various teachers from the chief directress down (or up?) to the instructor in cooking. All should be selected with special reference to their fitness for their responsible duties. Those who set out to teach should themselves be experienced in what they teach, and their own practices should exemplify their precepts.

The curriculum should cover the whole ground of a nurse's duties, but no more. Nurses are to be nurses, and not physicians, or alienists, or Boards of Health.

In their course of training, which surely requires, together with their other duties, where their school is in connection with a hospital, all the energy of which they are capable, care should be taken to waste none of it uselessly on work which exacts no repetition in order to attain proficiency, or on work of such a kind as they will only in very exceptional cases be called upon to perform. By thus avoiding waste of time and energy in purely "unskilled labor," they may devote themselves more assiduously to acquiring skill in those manipulations which belong distinctively to their profession as nurses.

There seems to be a decided preference for surgical nursing, both before and after graduation. Why this should be we cannot say, unless it be due to the same feeling that prompts so many medical students to devote their best energies to surgery, viz., the desire to see tangible and immediate results—results,

either death or recovery,—a successful operation in either case—as the outcome of professional interference.

It may also be that it is recognized that it is more difficult to be a good medical nurse than it is to be a good surgical one, the former calling into play all the finer qualities and traits of character which are essential to the composition of a born nurse. This predilection for the surgical side of their profession should not be allowed to weigh in the arrangement of the curriculum, nor should the nurses be allowed to become specialists before they have received their diplomas.

Graduates trained, as we have indicated, in training-schools conducted on the lines set forth, will surely overcome any prejudice which may still exist in any quarter against the “trained nurse.”

W. H. B.

THE TREND OF MEDICAL EDUCATIONAL METHODS IN AMERICA.

THE recent announcement of the plans for the new buildings of the Harvard Medical School serves to emphasize one trend of teaching in American medical schools. Stated briefly, the plans contemplate the erection of seven buildings on a 26-acre plot of ground situated at some distance from the built-up portion of the city of Boston. Five of these buildings will be for the use of the medical school, one for the dental school, and one is to serve as a power-house. Of the five medical buildings, four will be given up to laboratories and one will contain lecture-rooms. “It is proposed to eventually erect a hospital.”

Thus we perceive that the Harvard Medical School remains true to its traditions. The visitor to its present building in Boylston street has been wont to express surprise that a school rated so high should possess no clinical facilities, either hospital or dispensary, as an integral part of its equipment, or at least in an immediately accessible neighborhood. As a matter of fact, a comparatively long journey, which must consume considerable of the medical student's limited time, is required to reach the Massachusetts General or Boston City hospitals; and it is upon these, almost alone, that the students must rely for clinical instruction. With the school established in its new location, the difficulty of access to any hospital instruction must

become so great that the course will tend more and more to limit itself to laboratory and didactic instruction.

The Johns Hopkins Medical School presents the most notable antithesis to that of Harvard. In fact, the Baltimore institution goes to the other extreme; it does not possess a single lecture-room, and the student spends his entire four years in the hospital or dispensary, or else in the associated laboratories. He hears scarcely one didactic lecture during his entire course; his instruction is simply incidental to practical work.

In these Boston and Baltimore schools we see exemplified the two extremes of our present educational methods. That both are successful, at least in one respect, is demonstrated by the high marks secured by their respective graduates in the theoretical examinations conducted by the various State Boards. It would be interesting, however, were it possible to observe and compare the methods pursued by these respective graduates when they finally come face to face with disease at the patient's bedside. To the unprejudiced observer the Johns Hopkins method must appeal as undoubtedly the more rational. It recognizes the fundamental fact that the patient is the centre about which all medical knowledge should be grouped, and it makes no attempt to utterly divorce the laboratory from the bedside. It is questionable, however, whether it would be so completely successful were it not limited to classes of picked students—students already possessed of a general scientific training and a special knowledge of biological methods which places them almost on the level of the second or third year students of the old-time medical school. Such training has already produced an admirable group of original investigators and teachers, of whom the whole country is proud. But the fact remains that the demand for original investigators, while great, is not supplemented with endowments sufficient to support more than a comparatively small number of men, and that the principal opening for the medical graduate in the future, as in the past, will be in the practice of his profession. Unfortunately, too, he will in most cases have to be skillful enough to detect and conquer disease without all the ponderous equipment of the modern laboratory. To a large part of the profession the special laboratory and dead-house must remain

closed. To them, instead, the opportunity will be given to conquer disease with the aid of the ammunition carefully prepared by the smaller group of investigators; and so each will have his essential part to play.

The principal fact, at any rate, is that most of the medical schools must continue to turn out practicing physicians. Such men must be, above all things, practical; and this they can never be until they have served their apprenticeship at the bedside in some institution where the patient, and not the laboratory, forms the nucleus. The senior medical student, in the future as in the past, must "walk the hospitals" for the best of his knowledge. Yet it is doubtful whether the didactic lecture can ever be abandoned entirely. As a means of correlating the knowledge gained in laboratory and clinic its value cannot be doubted, and it must continue to fill-in some gaps in the student's knowledge which even the most extensive hospital service cannot entirely bridge over. To be effective, however, it must be clear-cut, analytical, and must come from the lips of one who has not only knowledge, but the power to impart it. Unquestionably, too, the recitation or "quiz" system is becoming a necessary adjunct to the lecture.

While at present there is a tendency in some quarters, no doubt largely reactionary, to demand the total abolition of the lecture system, we believe that in the future the tendency of medical instruction will again be toward the "middle of the road"—toward that judicious combination of clinical and didactic teaching which now, as in the past, seems best exemplified by the methods pursued in the great Philadelphia schools.

ECCENTRICITY AND BRAVADO!

THE daily newspapers give reports of physicians desirous of expressing their beliefs in the non-contagiousness of small-pox and the inefficiency of vaccination as a preventive, giving practical evidence of their heresies by voluntarily exposing themselves and others in the most absurd way. As long as such reports related to old-school physicians we had nothing to say; but when members of our own school participate in such inanities, we feel that it is time to utter a few words of emphatic disapproval as voicing the sentiments of our branch

of the profession. If the evil results of their delusions were visited upon themselves alone, no one could complain; but they become an important means of carrying the contagion far and wide! A practical illustration of those having eyes seeing not has just been called to our notice. Two physicians, both prominent anti-vaccinationists, both disbelievers in the germ theory, attended a case of small-pox. In each instance the disease has been carried home to their families. It is to be regretted that the effects of the follies of these individuals were visited upon innocent parties.

In the case of a third disbeliever in vaccination the effects fell upon himself, for he is now ill with small-pox. A fourth man attempted to show his contempt for the contagiousness of small-pox by removing a patient with that disease to his own home, whereupon his outraged fellow-citizens burned him in effigy. Such eccentric conduct on the part of members of a liberal profession is to be deplored.

CONFIDENTIAL!

WE have been the recipient of the following circular, accompanied by subscription blank:

OFFICE OF PRESIDENT

PRESIDENT

PHARMACY CO.

JANUARY 9, 1902.

Dear Doctor: The annual meeting of the stockholders of this Company will be held January 20th. We have a large cash surplus on hand, amounting to nearly Thirty Thousand Dollars (\$30,000.00), which will undoubtedly be paid out in dividends. If you are contemplating subscribing for stock in this Company, do so now before the close of the books, January 20th, and you will be in time to receive the January dividend, the first dividend declared this year.

We have a small amount of stock still left to be sold, and we would be glad to have your application before this has been entirely subscribed for.

The stock now on sale can be bought for \$10 per share. When this has been exhausted the price will be increased possibly to \$12 or \$15 per share.

Sign the enclosed blank, and send us your check, and we will issue the stock at once.

Very truly yours,

Confidential.

————— PHARMACY COMPANY,
 ST. LOUIS, CHICAGO, NEW YORK,
 Capital Stock, \$600,000, Full Paid, Non-Assessable.

WHEREAS, I have this day subscribed for ——— shares of the capital stock of the ——— PHARMACY COMPANY, par value \$10.00 each, amounting to ——— Dollars (\$———), and will participate in all profits and dividends declared by said corporation from date; *I hereby agree to use my best efforts to promote the interests and advance the sale of the products of said Company in general.*

(Signed) _____

(Witness) _____

(Date) _____

Concerning the wisdom of the above quoted circular from a business standpoint, we have nothing to say. But we do object to the prostitution of the profession by the insertion in the subscription blank of the clause we have italicized. No merchant with any business foresight would sign such a pledge. No physician who has the good of his profession at heart would think of doing so. No wonder the president of the company marked the communication "Confidential."

Commercialism is rapidly prostituting medicine, and it is time for every self-respecting physician to do all that may lie in his power to put a stop to it. The above is not the only method employed to this end. Journals all over the country are being offered stock in payment of advertising, the idea being that the journals accepting the offer will make special efforts to make such stock profitable. In other cases, advertisers say in so many words that they will withdraw their support from journals unless original articles recommending their wares are inserted. We are glad to say that the manufacturers pursuing this course do not prepare a product likely to be long in professional favor. The reputable class of pharmacists are willing to let their goods sell on their merits, without employing any chicanery to promote their sale. We may also add, with pleasure, that none of the medical journals having a subscription list cater to the commercial spirit.

GLEANINGS.

HYOSCIN AS A TEMPORARY SEDATIVE IN MENTAL DISEASES.—Drs. Garnier and Cololian, in cases where it is necessary to quiet down a furious maniac, in order to transport him some distance, as, for example, from his home to an asylum, speak highly of hypodermatic injections of hyoscin hydrochlorate as a temporary sedative. It will bring about several hours of quiet, or, if given in larger doses, sleep. It is merely a palliative, not a curative. (?) Though it may be given by the mouth or rectum, yet it is usually administered subcutaneously, in doses of one-half to two mgms.—*Journal des Praticiens*, No. 51, 1901.—(It is more than a palliative in some conditions of mental agitation, notably those complicating infectious diseases, as pneumonia and typhoid. Of course it is here used in much smaller doses.)

Frank H. Pritchard, M.D.

PERIPHERIC FACIAL DIPLEGIA, PROBABLY FOLLOWING MUMPS.—Dr. Hirtz, of Paris, at a recent meeting of the Hospital Medical Society of that city, presented a girl of sixteen, without personal or hereditary antecedents worthy of note, who was affected with a peripheral facial diplegia. When she entered the hospital the right side of her face presented the reaction of degeneration, while on the left electric contractility was normal. Now, after several treatments by electricity (what current not stated) and massage, the paralysis of the left side has wholly disappeared, and that on the right is merely a slight paresis. The origin of this paralysis was somewhat doubtful, though it seems that she must have had the mumps, for several days before it appeared both her parotid glands swelled somewhat and were painful. M. Joffroy has published such a case, and similar cases have been reported by others.—*La Semaine Medicale*, No. 49, 1901.

Frank H. Pritchard, M.D.

ACUTE PERICARDITIS OF NEPHRITIC ORIGIN.—Dr. Ferrier communicated to the same society a case of chronic Bright's disease in a soldier, who died after having suffered for three days from uræmic symptoms, complicated by acute pericarditis. The necropsy revealed, besides the usual lesions of an old nephritis, a very abundant sero-purulent effusion in the pericardiac cavity, which latter was covered with pseudo-membranes. Curiously enough, only a few coli-bacilli were found in both the exudate and in the false membranes, which were probably of cadaveric origin. In short, it was an amicrobic inflammation. This case deviated from the usual type of pericarditis accompanying Bright's disease—*péricardite brightique*—which is generally circumscribed, subacute or chronic, and without exudate.—*La Semaine Medicale*, No. 49, 1901.—(Dr. Samuel West, in his "The Lettsomian Lectures for 1900 on Granular Kidney," speaking of acute pericarditis, dwells particularly on the great gravity of this complication in this condition. "It is always a very severe complication, and even where it does not itself cause death, it is a

warning that the end is near." He cites an instructive case. "I was asked to see a gentleman in consultation because he had suddenly developed pericarditis without any obvious cause. I found the patient in bed, well nourished and muscular, with a somewhat sallow, unhealthy complexion, looking not seriously ill. There was well-marked pericarditis, friction being unusually loud. His breath was slightly short and his pulse a little hurried, but, except for feeling generally ill, he seemed to have nothing to complain of. The urine contained a small amount of albumin, the arteries were thickened, and the tension raised.

"The patient had been in perfect health until three weeks before I saw him. He had been hunting two or three times a week, and it was because he could not see the wire fences that he began to feel uneasy about his eyesight, which on one occasion caused him to get a fall. The eyesight gradually got worse, and it was this only which took him to the doctor. A week or so before I saw him his vision had become so considerably affected that he could not read at all; the pericarditis was then discovered by accident, and he was then sent to bed, much against his will. Ophthalmoscopic examination showed the most extensive albuminuric retinitis, with numerous white patches in both eyes, and a few hæmorrhages; the disks were greatly swollen, so that the condition fully explained the loss of sight. The breath was somewhat urinous; the quantity of urine passed was sufficient in amount, but the specific gravity was low. A very grave prognosis was given, and in the course of a few days the patient died. Now, this patient had thought himself to be in perfect health, and was out hunting only a month before his death.

"The pericarditis may produce no symptoms and only be discovered accidentally.")

Frank H. Pritchard, M.D.

INTESTINAL OBSTRUCTION BY BILIARY CALCULI.—Dr. Karewski, of Berlin, at a recent meeting of the Society for Internal Medicine of that city, read a paper on this subject, in which he reported five cases with one death. It is a very rare condition, of which the diagnosis is very difficult, for the symptom-picture is quite variable. Indeed, the patient may not have had classical attacks of gall-stone colic, or, at the most, have had them a long time previously. On the other hand, the obstruction may not be permanent, but be alternated with periods of good health; finally, the calculus may not be passed by the anus, but ulcerate through the intestine into the peritoneal cavity and bring about inflammatory symptoms, followed by adhesions. Again, the concretion may have been for years in the intestine. Such large stones, of course, cannot pass through the ductus choledochus, but by pressure cause adhesions to form which allow the calculus to ulcerate through into the intestine. If it pass into the colon, the dangers of obstruction are but slight, though it has occurred. It is usually the duodenum which is involved, and the small intestine grows smaller in size down to the ileo-cæcal valve; hence the probable difficulty of passing. The partially inflamed gut also refuses to dilate, and the too large stone cannot pass through a small gut. A diagnosis is only to be made with a certain degree of probability: the advanced age of the patient; the sex, female, for it is known that women are more often affected than men; the alternating periods of occlusion and permeability of the intestine, and the symptoms pointing to an obstruction situated high up in the bowel. The question in treatment is whether to operate or not. Years

ago, expectancy yielded better results than the operation, though nowadays, after failure of medicinal measures, an operation is decidedly indicated.—*La Semaine Médicale*, No. 49, 1901.—(I had such a case last year, where olive oil and atropine, subcutaneously, brought my patient through safely. I reported it in this journal and in the *Muenchener Medicinische Wochenschrift*.)

Frank H. Pritchard, M.D.

EXOPHTHALMIC GOITRE IN A YOUNG CHILD.—Dr. Roy, at a recent meeting of the Medical Society of the Hospitals of Paris, presented a little girl of four and a half years who was suffering from the symptomatic triad of Basedow's disease—goitre, exophthalmia and tachycardia. Thyroid preparations were ordered, and since then her pulse has fallen from 168 to 140, the anæmia has disappeared, and her weight has increased 3 kilograms. "This is the youngest case of Basedow's disease yet recorded." In the discussion M. Marie stated the thyroid feeding seems to be more harmful than useful in exophthalmic goitre; on the contrary, in those goitre cases which later developed exophthalmic symptoms, this treatment has had a favorable influence both on the goitre and the basedowic symptoms. M. Joffroy asserted that thyroids almost invariably aggravate exophthalmic goitre. He has even seen very pronounced symptoms of asystolia follow the use of thyroids in goitres which developed into exophthalmic ones. He cannot support the distinction which M. Marie would make. M. Rendu, on the contrary, has observed a manifest amelioration in a young girl with Basedow's disease, after thyroids. He would explain this difference of action to some cases being of toxic while others are of neuropathic origin.—*La Semaine Médicale*, No. 51, 1901.

Frank H. Pritchard, M.D.

MORE LITERATURE ON ATROPINE IN ILEUS.—In the *Centralblatt für Chirurgie*, No. 48, 1901, a number of articles on this subject from German sources are abstracted. Gebele (*Muenchener Med. Wochenschrift*, No. 33, 1901) criticises those cases which have been reported to date, and asserts that atropine is only indicated in faecal impaction with ileus-like symptoms, or in conditions which run their course under the clinical picture of a secondary reflex spasm of the bowel. His case had been treated with atropine for several days before it came under his care. It was a good test-case to show how easily one might be mistaken and lose valuable time for operative measures. The seeming improvement was followed by a very acute aggravation. The patient, a woman of seventy-two years, was operated on and died, as was ascertained at the necropsy, from a severe peritonitis due to gangrene of the gut from impaction of a faecal stone (enterolith).

I reported a somewhat similar case of intestinal obstruction from a large-sized gall-stone in a man of some sixty-two or -three years, which was, on the contrary, successfully treated with good-sized doses of atropine hypodermatically and olive oil internally. This case was also reported, in English, in the *HAHNEMANNIAN MONTHLY*, p. 702, 1901, as well as in German in the *Muenchener Medicinische Wochenschrift*, No. 33, 1901.

Aronheim (*ibidem*) observed a case of faecal obstruction with signs of ileus which was relieved by 3 mgms. of atropine. Professor Schulz (*ibidem*), of Greifswald, stated that the various preparations of belladonna were employed in incarcerated hernia and ileus by physicians in the beginning of the nineteenth century. I would suggest that hyoseyamin might fully as well be

employed as atropine, and, indeed, preferably, on account of its lesser tendency to be "inflammatory."

Frank H. Pritchard, M.D.

GANGRENE OF THE LIMBS AFTER INFECTIOUS DISEASES.—Professor Eichhorst reports the case of a child of one year who, after a very severe attack of scarlet fever, was affected with gangrene of one foot and the lower portion of the leg. Amputation below the knee was followed by uncomplicated healing. Gangrene after scarlatina is very rare, for he has been able to find but two such cases, and those both in children. The first symptoms in his case were noticed during the third week, in the other two somewhat earlier. From microscopic examination of the tissues a local endarteritis was detected, which would point to thrombosis rather than to embolism, to which the other two cases were attributed. Only a microscopic examination will reveal endarteritis, for at times the gross appearances do not seem to be characteristic. He has collected all the observations of gangrene following infectious diseases, and has found them to be about 166 in number. Of these, 40 followed typhoid fever; 19 the grippe; 10 pneumonia; and 5 the measles, to mention some of the more prominent diseases. The lower extremities were most often affected (122 cases), and the upper seldomer, proportionately. In 4 cases both the upper and lower extremities were involved. It is always a very grave complication, for about one-third of the patients have died; especially is gangrene complicating the influenza of serious import.—*Hospitalstidende*, No. 48, 1902.

Frank H. Pritchard, M.D.

SYPHILIS OF THE BRAIN DIAGNOSED BY LEUCOPLASIA OF THE TONGUE.—Dr. Gaucher, of Paris, communicated to the Medical Society of the Hospitals of that city the case of a man of sixty years who, after an apoplectic attack, was affected with right-sided hemiplegia, involving the face, and accompanied by hemichorea, hemianæsthesia and contractures. Although the patient denied ever having had syphilis, two small areas of lingual leucoplasia were detected, which led to the thought that syphilis might be the cause of the hemiplegia. Two cgms. of the benzoate of mercury were given him under the skin every day, and the iodide of potassium administered at the same time. Already in four days the paralysis had wholly disappeared, there only remaining slight choreiform movements, a little exaggeration of the patellar reflexes, and a little less sensation (hyperæsthesia) of the right side. The writer asserts that buccal leucoplasia is always of syphilitic origin, though mercurial treatment is often inactive in this disease. Discussing this case, M. Merklen would be somewhat reserved as to the invariable specific origin of leucoplasia, for he has seen a patient with this lesion contract the syphilis. In answer, M. Gaucher said that the syphilis might be of heredo-syphilitic or conceptional origin, and it is well established to-day that one with hereditary syphilis may contract syphilis.—*La Semaine Médicale*, No. 50, 1901.

Frank H. Pritchard, M.D.

CASES ILLUSTRATING URETERAL SURGERY.—Coe (New York) reports three interesting cases of ureteral anastomosis. In the first case the left ureter was cut during an operation for the removal of a large uterine fibromyoma. The ureter was much displaced and was not recognized till after it was clamped, along with the displaced uterine artery, and severed. The

proximal end was freed from the ligature and was identified by the escape of urine. It was surrounded by gauze and allowed to remain till the close of the operation. As the ends could easily be approximated, uretero-ureteral anastomosis was performed by the lateral method advocated by Van Hook and Kelly. The united ends were covered with a flap of peritoneum, and the subperitoneal space drained per vaginam. Urine was passed daily, varying from thirty to forty ounces, till the sixth day, when a leakage was noted. The patient remained in the hospital for six weeks. The vaginal healed so that the opening could not be identified. The dribbling occurred only when the patient was up and about, so that it was inferred that there was a small valve-like opening at the point of anastomosis, and not a complete separation of the ends of the ureter. A year after the operation the fistula had entirely closed.

In the second case the left ureter was torn across during an enucleation of a double intraligamentary dermoid cyst, with universal intestinal and intrapelvic adhesions. The ureter was not identified till removal of the tumor. It was found that the distal end was so distended that the proximal end could easily be invaginated into it to the distance of an inch without danger of constriction. The ends were secured with sero-serous sutures. In attempting to pack the pelvis with gauze, traction was made on the ureter and the ends drawn apart, so that it was necessary to do the work over again. In spite of this the patient made a good recovery, passing a normal amount of urine from the outset, and was discharged cured four weeks after the operation.

In case three, during a secondary operation for the removal of a large myxangioma, which had undergone sarcomatous degeneration, there was found attached to the removed mass a portion of the trigone, an inch square, and at least an inch of the left ureter. The right ureter had been also severed close to the bladder. Although the patient was in collapse from loss of blood, the wound in the bladder was closed with superficial and deep sutures, the end of the left ureter being turned into the bladder at a point where the tension would be least, and secured. The right ureter was much dilated, and the tension such as to render it impossible to draw it down. Gauze was packed into the pelvis and a catheter left *in situ*. During the first week from thirty to thirty-five ounces of normal urine was discharged through the wound. Eventually most of the sutures gave way, and a large fistula two inches in diameter remained. Two months later another operation was undertaken for the repair of the fistula. The uretero-vesical anastomosis on the left side had been entirely successful. The end of the right ureter had become adherent at the edge of the fistula. It was dissected off and turned into the bladder. The edges of the fistula were then split and rolled inward. The vaginal edge was denuded and the cervix uteri utilized to fill-in the upper part of the gap. The patient ultimately made a good recovery, having no vesical symptoms whatever.

The author states that when it is established beyond a doubt, by the escape of urine, that a ureter has been divided, nothing except the absolutely desperate condition of the patient should deter the surgeon from at once attempting to repair the injury, instead of resorting to the unsurgical makeshift of suturing the end of the ureter in the abdominal wound, or to the serious procedure of removing a healthy kidney from a patient already depressed by a long and bloody operation.—*American Journal of the Medical Sciences*, January, 1902.

Gustave A. Van Lennep, M.D.

PREVENTION OF STITCH ABSCESS.—Maylard (Glasgow) says: "The two places at which it is possible for micro-organisms to be liberated, and when set free develop or multiply, are the edges of the wound, both superficial and deep, and the channels made by the stitches."

The author holds that practically every wound made by the surgeon is septic, on account of the naturally septic conditions of the skin. The latter, with its secreting glands and lymphatics, contains micro-organisms, and these cannot be got at by the ordinary methods in use, of watery antiseptic solutions. These same organisms are liberated, and find a nidus for development in the various wounds made by the surgeon in the operative treatment of disease.

No amount of scrubbing with soap and water, antiseptic solutions, fat solvents, etc., can dislodge these germs and render the skin aseptic. The author has followed the following method:

1. Cleanse the skin in the usual way, by soap and water (turpentine and alcohol or ether, if necessary).

2. Anoint freely and widely with hydrated lanolin—oleate of mercury (20 per cent.)—and rub in; besmear a piece of lint with the same, and leave on until a second inunction is performed, twelve hours later. Every case should be treated for at least twenty-four hours before operation; preferably forty-eight hours should be given, with at least two separate periods of "rubbing in" for about ten minutes on each occasion.

3. On the operating table the piece of lint is removed and the superfluous ointment rubbed off with a piece of, sterilized gauze. The part is now ready for operation.

The following conclusions were arrived at in a series of experiments:

1. As to the presence of mercury in the tissues, the chemical examination failed to afford any positive information. Either mercury was in too small quantities to be detected, or its absorption and transit through the lymphatics too rapid to be caught for analysis.

2. The bacteriological examination proved a material diminution in the number of micro-organisms present. That any should be present at all is probably to be explained by the fact that the ointment cannot reach all the seats where they exist.

3. The clinical records seem to afford incontestable proof of the value of the method. That microbes were in all probability present in the tissues operated upon and yet failed to develop into a pathological process is thus explained. The sterilizing effect of the inunction is productive of two results—it kills every organism in the lymphatic channels, and so influences the living tissues that they can successfully inhibit the further development of those which remain.—*Annals of Surgery*, January, 1902.

Gustave A. Van Lennep, M.D.

THE TECHNIQUE OF GALL-BLADDER AND DUCT OPERATIONS.—Mixer (Boston) advises against the use of rubber gloves while performing operations upon the gall-bladder, as so much depends upon the sense of touch that even the hand trained to operate in gloves cannot, as a rule, do as good work with as without them. The best incision to use is one through the outer part of the rectus parallel to its fibers. Should more room be needed, it can be carried upward and across the rectus.

Small stones in the common and even cystic duct, and still more so in the hepatic duct, may easily escape the careless or hasty operator. The best method of examining the ducts by touch is to pass the forefinger of the left hand through the foramen of Winslow, the surgeon's back being toward the patient. The duct, portal vein and artery are then easily felt between the finger and thumb.

The gall-bladder, if it is to be opened, is best secured by two ligatures passed through its wall by curved needles. These do much less damage and take up less room than forceps. Should there be a large quantity of fluid in the gall-bladder, it may nearly all be removed by means of an aspirator or trocar. Every gall-bladder once opened should be drained. The old and common method of stitching the gall-bladder to the abdominal incision, or even the skin, is now crude, and should be discarded. The best method is to tie a glass tube with a flaring end tightly into the gall-bladder, using a silk ligature. The ragged end of the gall-bladder is then trimmed away, and it and the tube are enveloped in a small packing. A rubber tube being attached, all the bile for days may be carried through the untouched and unsoiled dressing into a bottle hung below the bed. Cholecystectomy may be done simply, without the use of a cautery knife or special instrument, by dividing the peritoneum at its reflection from liver to gall-bladder, when the latter is easily torn from its bed by the fingers or blunt dissector till the cystic duct is reached, which can be tied and cut, and the operation done.

The author has never seen a hæmorrhage from the torn liver substance that a packing of gauze would not stop in a few minutes.

Stone in the common duct may be removed, according to its distance from the bowel, either through the enlarged cystic duct, the incised common duct, the incised duodenum, or even by crushing by external pressure. Openings made in the common duct may be stitched up with the help of Halsted's mallets, or left opened and drained. Those cases in which no sutures are used do as well as, if not better than, those where they are.

Cholecystenterostomy is easiest done with the help of the Murphy button. The elastic ligature, however, may be substituted here with the best result. One thing the operator should always remember is that a biliary fistula cannot be, and really should not be, closed unless the common duct is open.

The hæmorrhage that sometimes follows operations upon profoundly jaundiced patients is most trying and difficult to control. Finely divided gelatin, sterilized and perhaps mixed with a little adrenalin, might be used on the cut and torn surfaces.—*Annals of Surgery*, January, 1902.

Gustave A. Van Lennepe, M.D.

A CASE OF PREMATURE SEPARATION OF THE PLACENTA AT THE NORMAL SITE. VAGINAL CÆSARIAN SECTION.—(Rühl.)—Rühl was summoned in haste and found a strong, well-developed woman unconscious, with a weak and somewhat rapid pulse. A considerable quantity of blood—about 500 gr.—had escaped from the vulva. She had borne two children; the youngest was three years old. She had always been well, and there was no nephritis or other known disease predisposing to the premature separation of the placenta. The day previously she received a slight knock on the abdomen, but attached no importance to it. At noon the next day, while she was feeling perfectly well, she felt a slight labor-like pain, and then suddenly followed a very severe

pain, as if something tore apart in her abdomen. At the same time there was a small hæmorrhage from the vagina. She fell from the sofa, where she was sitting, to the floor, and became unconscious. He examined her within half an hour from this time. The fundus uteri was near the ribs on the right. The uterus was apparently of normal configuration except on the right side of the body, where it seemed somewhat stout. The parts of the child were indistinct and scarcely to be felt. Motion could not be felt, and there were no foetal heart-sounds. The vagina was filled with coagulated blood. The cervix was undilated, firm, rigid, and scarcely admitted the tip of the index finger up to the internal os. The membranes were unruptured and stretched by slight pains. No placental tissue could be felt at the internal os. The patient meantime recovered consciousness and complained of labor-like pains. Some blood continued to dribble away and became quite profuse during the pains.

The diagnosis was made of separation of the placenta at its normal site, and a colpeurynter was put in the uterus to hasten labor, dilate the cervix, and by keeping the membranes intact to restrain the hæmorrhage.

These expectations were not fulfilled. The external hæmorrhage was arrested, and considerable traction on the colpeurynter was exerted to promote dilatation of the cervix. Within fifteen minutes after the introduction of the colpeurynter there was a marked change in the condition of the patient. She gasped for air, exhibited great anxiety, became suddenly unconscious and pale, and the radial pulse scarcely could be felt. The anterior wall of the corpus and fundus uteri showed a large projecting tumor the size of a man's head, plainly starting like a welt from the cervix. The patient was becoming more and more collapsed every minute. The colpeurynter was withdrawn without accomplishing any dilatation of the cervix, and vaginal Cæsarian was performed immediately, during which saline infusions were made. The cervix was split anteriorly and posteriorly, as vaginal uterine fixation, which required three minutes. There was little hæmorrhage. Two large vessels were clamped. The membranes were ruptured. The head presented and was delivered rapidly by the forceps. The placenta followed spontaneously. The time from the first incision to the delivery of the child was six minutes. A large quantity of blood and clots followed the delivery of the child. The uterus contracted. The cervix incisions were sutured and the patient slowly recovered with the aid of saline infusions, camphor injections, nutritive enemata, etc.—*Centralblatt für Gynakologie*, No. 47, 1901.

George R. Southwick, M.D.

A CASE OF FATAL ACUTE LEAD POISONING IN PREGNANCY.—(Pilsky.)—The patient was a woman six months pregnant, who had taken vaginal douches twice daily of one to two tablespoonfuls of acetate of lead to one litre of water. She was suddenly taken sick with severe vomiting and intestinal colic, there was spontaneous premature labor. On the following day there was a high fever with a good pulse, and severe vomiting which became bloody on and after the third day. The temperature was 37° to 38.7°, with a full, strong pulse, which on the third day went down to 54 to 58. There was a high degree of icterus. The patient collapsed on the fifth day, and died on the same day with increasing weakness of the heart. The necropsy evidence was against septic endometritis and peritonitis. Chemical examination of

the liver, kidneys, spleen, stomach, lungs and feces showed a large amount of lead.—*Centralblatt für Gynakologie*, No. 47, 1901.

George R. Southwick, M.D.

LEAD PILLS TO PRODUCE ABORTION.—(Wrangham.)—Women in the districts of Leicester, Nottingham and Birmingham not infrequently take lead pills to produce abortion. The writer publishes five of his observations in Sheffield. All the women showed severe symptoms of poisoning, chiefly in the nervous system. Four patients had serious disturbance of vision and disturbances in the region of the oculomotorious.—*Brit. Med. Jour.*, July 13, 1901.

George R. Southwick, M.D.

OPERATIVE INDICATIONS IN FIBROID COMPLICATED BY PREGNANCY.—(Délagenière.)—He divides them into two groups. In the first, those in which the tumor only is removed, and the second in which both tumor and uterus are removed. In the first class of cases, if the tumor is pediculated, extirpation is easily performed. If the tumor has a broad base of attachment, enucleation is difficult, and brings the double danger of infection and abortion. If the tumor is in the broad ligament, enucleation is easy in the first month, and difficult and not advisable in the later months of pregnancy. In the second class of cases there are also three possibilities. First, supra-vaginal hysterectomy can be performed with the formation of an external stump; second, supra-vaginal hysterectomy, after or without Cæsarian section; and, third, total hysterectomy. The last two methods deserve the preference, and if the vaginal vault can be preserved, supra-vaginal amputation should be performed, as it simplifies the operation and reduces the danger of infection from the vagina to a minimum. If the woman has already been infected, total extirpation should be done.—*Centralblatt für Gynakologie*, No. 47, 1901.

George R. Southwick, M.D.

SPINAL ANÆSTHESIA.—(Bier.)—About twelve hundred operations have been performed by this method. Loss of sensation occurs in from one to fifteen minutes after the injection of a dose of 0.005–0.03 g. cocain. It begins at the feet, but occurs often earlier about the region of the anus and of the genitals. It lasts from thirty minutes to two hours. It is quite short and uncertain on the upper parts of the body, but is more profound on the lower extremities, and permits the performance of major operations. It is, however, associated with great discomfort and serious danger, which is so great that the writer advises against its general use in this matter. He sought some agent to replace the cocain, but found the anæsthetic effect diminished with the toxicity of the drug. He advises a rubber band about the neck to diminish the amount of poison carried to the brain, and that the patient should eat before the operation and drink during it. Analgesia will occur with small doses, but the patient will retain sensitiveness to touch and temperature, so that everything is felt, but no pain is experienced. The writer warns against the general use of the method, which should be limited to operations about the anus, perinæum, pelvis and bones, as small doses are sufficient.—*Archiv für Klin. Chirurgie*, Bd. lxiv, Hft. 1.

George R. Southwick, M.D.

SINGLE FORWARD DISLOCATION OF THE SEMILUNAR BONE.—Catherwood (New York) cites a rare and interesting case of single forward dislocation of the semilunar bone. The patient, a man of 48 years, gave the history of having fallen downstairs, receiving the bulk of the force on his hand, while in the over-extended position. When first seen the fingers were considerably flexed, and practically fixed in that position, there was great tenderness over the radial side of the wrist-joint, and loss of function of that hand was almost complete. The diagnosis of Colles' fracture was made, which later was found to be in a measure correct, by means of the X-ray. On the anterior surface of the radiocarpal articulation a large but well-fixed piece of bone was felt, which could not be accounted for as coming from either radius or ulna. On the dorsum of the wrist, just over the spot where the semilunar bone should have been, a distinct depression was made out. With these points dislocation of the semilunar bone was diagnosed, which later the X-ray proved. The patient refused proper treatment.—*Med. Record.*

B. E. Bigler, M.D.

LOCAL GANGRENE IN ACUTE BROMINE POISONING.—Dr. Darnall (Llano, Texas,) reports a case of local gangrene, in acute bromine poisoning, which occurred in an opium habitué, to whom he had been administering sodium bromide, two ounces to six of water, with directions to take a teaspoonful every two hours until sedative effects were produced. The patient (a woman) had the bottle refilled twice, without the physician's knowledge, making a total of six ounces taken in that number of days. The lesion began above the knee as a wheal, like that of urticaria, in a short time the spot became vesicular, and the surrounding tissue was swollen and indurated. In a few days over twenty of these spots appeared on the thigh. They passed rapidly from the stage of urticaria to that of gangrene. The usual treatment for local gangrene was resorted to, and the patient eventually recovered, both from the gangrene and the morphia habit.—*Medical Record.*

B. E. Bigler, M.D.

A CASE OF MYXŒDEMA, WITH A STUDY OF THE BLOOD AND THE URINE DURING TREATMENT.—(Prout.)—The broad symptomatology of myxœdema, indicating as it does a disturbance in the functions of various organs of the body, tends to some confusion in the interpretation of the functions of the thyroid gland. However, it is admitted, and the investigations of clinicians show, that the thyroid has to do with the matter of elimination or destruction of some substances which are prejudicial to the body, and which, if retained, will produce symptoms of an intoxication of a peculiar type, with an ultimately fatal result. It is also accepted that the administration of the desiccated extract of the thyroid will be followed by immediate benefit.

The case cited was a female, forty-three years of age, who began to rapidly increase in weight. There were unusual dryness and marked thickening of the skin in some places, especially the scalp, with areas of yellowish discoloration. The hair became brittle and began to fall out. The abdomen became pendulous and limbs puffed with a solid œdema. This peculiar solid œdema was present over the whole body. Nails were thick and brittle. Mentally, she presented a very poor memory, was dull and apathetic, indifferent and markedly suspicious, losing all interest in family matters. There was a marked disinclination for bodily exercise.

Urinalysis showed the presence of albumose, and a trace of serum

albumin. Specific gravity, 1007. Microscope revealed the presence of cylindroids and many epithelial cells. Urea in 24 hours was 16 grams.

Blood examination showed red cells to be 4,293,000, and white 7200 per c.mm.

The *treatment* was begun with 3 grains of the desiccated extract of the thyroid, and gradually increased to 9 grains daily. Once the medicine was discontinued because of the pulse becoming rapid and compressible. During the administration of the remedy the patient improved, and remained well to the time of writing, then nearly one year.

In summing up the treatment, the writer says: "I am of the opinion that the crowding of the thyroid is a mistake in the beginning of the treatment. The heart-muscle, from a long-continued absence of the thyroid secretion, is so poor and weak that it stands the primary depressing effect badly. The best effects are to be had from the gradually increasing dose, up to that quantity which will keep the body in the best state. As soon as the heart shows its effect in a weak and compressible, rapid pulse, then the indication is to reduce the daily amount.

As to the effect of the treatment on the urine, it can be said that the most marked is the increase in the elimination of urea. Albuminuria disappeared with the improvement in the general symptoms.

As to the blood changes, there was a marked decrease in the number of red cells. This is to be explained by an increase in the fluid elements by reason of the increased activity of the various organs. This action tends to disprove the view that the thyroid is directly a blood-forming organ. After the initial drop there was an increase in the number of red cells.—*The American Journal of the Medical Sciences*, December, 1901.

William F. Baker, A.M., M.D.

NATURE OF HERPES ZOSTER.—(Van Harlingen.)—After a thorough review of the literature of the nature of herpes zoster, the following conclusions are drawn, viz.:

(a) Under the designation zoster or herpes zoster is to be understood a specific infectious and possibly contagious exanthem, characterized in its invasion by lassitude, general malaise, chills, increased temperature and more or less digestive disturbance.

Following this, in most cases, neuralgic pains develop along certain nerve-paths or metameric areas, associated with the enlargement of lymphatic glands. After a period of several days the peculiar eruption shows itself and runs through a fixed cycle of development, acme and decline. The neuralgic pains now manifest themselves, and usually disappear with the eruption. In older persons the neuralgia is often a persistent symptom.

There may be at times a complication in the neighboring viscera, as in pleura, peritoneum and articulations.

(b) The affection attacks chiefly the posterior (sensory) ganglia and the Gasserian ganglion. From thence the inflammation may extend along the nerve trunks and fibres.

(c) Zosteroid eruptions are not infrequently met with in cases of poisoning from coal gas, after the ingestion of arsenic, following injuries of the nerves, as a result of moral shock, grief and hysteria.—*The American Journal of the Medical Sciences*, January, 1902.

William F. Baker, A.M., M.D.

THYROIDITIS COMPLICATING TYPHOID FEVER.—(Robertson.)—Inflammation in a healthy thyroid gland complicating typhoid fever is rather a rare condition, but its occurrence in a gland the seat of a previous hypertrophy is not uncommon. The case was a male, aged forty-two years, whose temperature had become normal, but complained of difficulty in swallowing, with a rapid, enlarging thyroid. Soon after he was taken with a chill, followed by a moderately raised temperature and marked dysphagia. These symptoms continued for several days, and were followed by a gradual increase in the size of the gland. The attack continued about ten days, and resolution took place.

When the left lobe of the gland is affected, dysphagia is apt to be more pronounced, owing to the greater opportunity for pressure, because of the left lateral deviation of the œsophagus. Dyspnœa is seldom severe and rarely associated with stridor. Hoarseness is exceptional. It is due to pressure on the inferior laryngeal nerve, which is situated between the lobes of the gland and the œsophagus. It is very rare that the pressure on the vessels gives rise to symptoms. All symptoms are apt to be more pronounced in suppurative cases, but very seldom threatening symptoms supervene. Again, in cases of deep-seated abscess there is a possibility of pus finding its way into the mediastinum or pleura. The abscess may be single or multiple and involve more than one lobe. As is characteristic of all post-typhoid lesions affecting the glandular system, they are to be found during the period of convalescence. The course of the complication is usually from ten to fourteen days.—*The American Journal of the Medical Sciences*, January, 1902.

William F. Baker, A.M., M.D.

OBSERVATIONS ON THE FREQUENCY AND DIAGNOSIS OF THE FLINT MURMUR IN AORTIC INSUFFICIENCY.—Thayer.—In 1862 Austin Flint called attention to the occasional existence, in uncomplicated aortic insufficiency, of a presystolic murmur limited to the region of the apex and distinct from the characteristic murmur of aortic regurgitation. This sound had all the characteristics of a mitral, direct, presystolic murmur. The following explanation was offered: "Experiments show that when the ventricles are filled with a liquid, the valvular curtains are floated away from the ventricular sides, approximating to each other and tending to closures of the auricular orifice. It has been shown that a forcible injection of liquid into the left ventricle through the auricular opening will cause a complete closure of this opening by the coaptation of the mitral curtains. In cases of considerable aortic insufficiency the left ventricle is rapidly filled with blood flowing back from the aorta as well as from the auricle before the auricular contraction takes place. The distention of the ventricle is such that the mitral curtains are brought into coaptation, and when the auricular contraction takes place the mitral direct current passing between the curtains throws them into vibration and gives rise to the characteristic blubbery sound or murmur. The physical condition is, in effect, analogous to contraction of the mitral orifice from adhesion of the curtains at their sides, the latter condition, as clinical observation proves, giving rise to a mitral direct murmur of similar character.

In 1883 Keyt proposed that it be called the murmur of Flint, and it has since been used by many. The conclusion reached, after discussing the mitral murmurs is that one may be justified in saying that in uncomplicated aortic

insufficiency a rumbling, echoing, presystolic or mid-systolic murmur limited to the region of the apex is very common.

The character of this murmur is in no way different from that commonly observed in true mitral stenosis, except that it is usually of moderate intensity. It is rarely associated with a tapping systolic impulse and a snapping first sound, which are the rule in true mitral obstruction, while the pulse is large and characteristic of uncomplicated aortic insufficiency. In the absence of these signs, and with a large pulse, the functional character of an apex presystolic murmur in aortic insufficiency is to be suspected, especially in cases where there is a history of acute infectious processes such as are ordinarily associated with endocarditis, and where there is evidence of a well-marked arterio-sclerosis. A Flint murmur may be associated with many of the clinical features of a true organic mitral obstruction.—*American Journal of the Medical Sciences*, Nov., 1901.

William F. Baker, A.M., M.D.

SURGICAL HINTS.—Never use sutures larger than are necessary to properly maintain approximation, or ligatures larger than will be sufficient to hold safely the vessels or pedicles they are to constrict. Even when absorbable they are foreign bodies.

If there is no evidence that a bullet has perforated important organs, such as the hollow viscera, or that it is causing hæmorrhage, or that it is producing dangerous pressure, no attempt at extraction should be made. The wound should be treated antiseptically. If sepsis should occur, the general rules governing the treatment of septic foci must be applied.

In a wound occurring in some place where no aseptic dressing can be procured, it is better to leave it exposed to the external air than to cover it with probably infected substances. A protective crust or scab will thus be rapidly formed.

Whenever tendons are sutured it is necessary to maintain the limb in such a position that the muscles whose tendons have been rejoined shall be as perfectly relaxed as possible. In suturing nerves the parts should be kept absolutely at rest for a period of three weeks.

In the case of a wound of the skull in which there is evidence of depression, even to a slight degree, and if the means of doing aseptic surgery are at hand, conservative surgery is out of place. It is now a cardinal rule that depressed bone in the skull must be elevated or removed.

In erysipelas of the face of uncertain origin, always examine the nasal cavity. The starting point of the infection is sometimes to be found in small purulent collections, confined beneath crusts, or in pustules situated around the hairs at the meatus.—*International Journal of Surgery*.

Herbert P. Leopold, M.D.

CANCER OF THE UTERUS.—Dr. Kelly in his splendid book has formulated a set of rules that should be followed by every physician, and the importance of living up to them should be impressed upon the laity:

1. It is the duty of every physician to see each of his patients at his office from two to three months after confinement, and to examine and carefully record the exact condition of the various pelvic structures, stating accurately just what lesions have been produced by the child-birth.

2. Cervical lacerations should be described with especial care, noting the position and depth of the tears and the appearance of the lips.

3. Every child-bearing woman who has passed thirty years of age, and whose condition has not been noted in this way, should consult a competent physician. If the cervical lips do not appear sound, she should be kept under observation and treated, if necessary, or examined every six or eight months.

4. Every woman thirty-three years or over who has a cervical tear should be examined at least once a year for ten years or longer, if the lacerated cervix does not present a perfectly healthy appearance.

5. The community at large should be so trained by the profession that any woman who suffers an atypical or unusual uterine hæmorrhage, or from any unusual discharge, should at once seek competent advice as to its cause, and the physician should not rest until he has ascertained its source. This rule holds with increased force in women in the forties, when both patient and doctor are so often deluded into a blind waiting for nature to relieve that which in time proves to be beyond both nature and art.

6. These rules apply with especial force to patients whose family history shows a liability to a cancerous disease.

Herbert P. Leopold, M.D.

THE PROGNOSIS, COMPLICATIONS AND TREATMENT OF TYPHOID FEVER IN CHILDREN.—Dr. Octave Ratier, of Paris, in a thesis admitting the accepted doctrine that this disease is particularly benign, as is taught by medical writers, would not advise one to be too much at ease in one's mind, for the majority of the complications which may affect adults may also appear in children, though less frequently. Intestinal hæmorrhages are infrequent, though the outlook is not as favorable as is generally taught, for out of 762 cases of fever in children there were 22 cases of hæmorrhage from the intestines, of which 10 ended fatally. Perforation of the intestine may also be observed in children. Several fatal cases have been noted during the last few years. Heart complications are more frequent than is usually thought to be the case, *but they must be looked for*. Especially the state of the pulse is indicative. In 30 cases where the pulse-rate was never over 110, all recovered, whilst amongst 70 whose pulse was over 110 there were 21 cases of death. A myocarditis is prone to complicate during the course or at the end of the first week, characterized by a weakness of the first sound of the heart, and later, in the third week, by increased frequency of the pulse, 120–130, cyanosis or collapse; arrhythmia, gallop-murmurs and other abnormal sounds have been noted. Pericarditis is relatively frequent, with or without effusion. During the course of the second week signs of an endocarditis may appear. On the whole, the heart stands the brunt of the disease better in children than in adults.

Complications in the nervous system are not infrequent in children, often from a hereditary predisposition. It is especially during convalescence that they appear, either as motor phenomena, paralyses, ataxia, or disturbances of sensation; aphasia has been noted, symptoms pointing to a disseminated sclerosis, neuritis, or even to a meningitis.

Besides these complications, stomatitis, otitis, abscesses of the muscles or osteomyelitis may set in; and, finally, Hutinel, during the epidemic of 1889, observed a peculiar skin disease characterized by irregular, erythematous blotches, symmetrically distributed over the extremities, and accompanied by fever.

Hence it follows that the outlook in typhoid is not always so invariably favorable. As to treatment, bathing is most useful. The child should be treated with reference to the individual case, for not all tolerate bathing equally well. Cool baths, from 27° – 25° C., as a rule, are agreeable to children, but they must be employed right from the beginning, when the temperature during the first 24 hours reaches 39° C. But one should accustom the little patients to that degree of cold by commencing with higher temperatures—for example, during the first few days, 33° , 30° , 27° C. The limbs should be lightly massaged and a cold sponge placed on the child's head. Some children cannot stand bathing at all, particularly cases with heart complications. Marfan first tries to reduce the temperature, if above 39° C., with quinine; but if this fail, he advises cool baths (32° – 25° C.), if necessary, every three hours.—*Hospitalstidende*, No. 45, 1901. (I never knew quinine do any good as an antipyretic in typhoid. It makes one feel that if he had left it alone he would have done better by his patient. Quinine is somewhat of a heart depressant, and seems to get "in the way of nature.")

Frank H. Pritchard, M.D.

THE DETECTION OF LOCOMOTOR ATAXIA IN ITS EARLY STAGES.—Fournier states that there are six special tests for bringing to light the earliest signs of inco-ordination. The first is Westphal's sign or the absence of the knee-jerks, found in two cases out of three in the preataxic period. Then there is Romberg's sign or oscillation of the body in the erect posture with the eyes closed; in the early stages this sign may take the form of nothing more marked than a slight balancing motion. Thirdly, there is the staircase test, or the difficulty experienced in going downstairs. Fourthly, the leg-crossing test consists in the fact that in executing this movement the patient passes his leg through a segment of a circle of unnecessary magnitude. Fifth is the test of walking and halting at the word of command, manoeuvres which are badly executed by the patient in the preataxic stage; turning quickly round at command will be done especially badly. The most effective test, however, is the sixth, viz.: standing on one foot first with the eyes open, and then with them shut; it may reveal a muscular disorder which has eluded many other modes of examination, and it is often most decisive. All the six tests, however, ought to be employed for the early detection of locomotor ataxia.—*Brit. Med. Journal*, Oct. 26, 1901.

F. Mortimer Lawrence, M.D.

THE CURE OF CHRONIC BRIGHT'S DISEASE BY OPERATION.—In a paper published in April, 1899, Edebohls, of New York, proposed the treatment of chronic nephritis by operation. The proposition was based upon the favorable results obtained in 4 out of 6 cases in which the writer had performed nephropexy for the purpose of anchoring a movable kidney in the presence of well-marked chronic Bright's disease.

The complete and permanent disappearance of albumin and casts from the urine, and the restoration to perfect health of 3 out of 5 of these patients, led the author to advise bilateral nephropexy in the case of the sixth patient. The latter was a sufferer from chronic Bright's disease complicated with movable kidneys, and operation was advised mainly with the object of favorably influencing the chronic nephritis. This operation, performed on January 10, 1898, was the first ever undertaken upon the kidneys with the deliberate purpose of curing chronic Bright's disease. As its result the patient was radically cured, and remains so to this day.

For a time the conception that the cure of the chronic Bright's disease was due to the correction of the displacement of the kidney prevailed, with the writer, but three secondary operations upon kidneys anchored some time previously persuaded him that the cure had, instead, been brought about by arterial hyperemization of the organ. In each of the cases connective tissue adhesions had attached the organ to its surroundings, and numerous large blood-vessels were found running to the kidney. An explanation of the effect of this increased blood-supply is found in Zeigler's statement that "when a portion of the renal epithelium has been destroyed by a morbid process which spares the interstitial structures, the loss is in general soon made good by regenerative proliferation of the remainder; and if the circulation is adequately maintained, the new epithelium presently becomes capable of carrying on the secretory function."

Edebohl's now reports in detail 18 cases operated by him, in all of which the diagnosis of chronic Bright's disease was based upon the patient's history, upon the chemical and microscopical examination of the urine by Dr. Henry T. Brooks, Professor of Pathology in the New York Post-Graduate Medical School, and, lastly, upon the actual inspection and palpation of the kidney at the time of operation. In 2 cases this was supplemented by microscopical examination of bits of kidney tissue removed at operation. Right nephropexy was performed upon 4 and bilateral nephropexy upon 12 of the 18 patients. Extensive denudation of the kidney cortex by stripping off the capsule proper, so as to lay bare one-half of the surface of the kidney, was a feature of each operation. Upon his last two patients he performed total excision of the renal capsule.

Of 9 patients thus operated upon a year or more ago, in only 1 case was there failure to radically cure the chronic Bright's disease, and in that case the patient lived eight years, for five years with only the operated kidney to depend upon, and finally died following a hysterectomy. Four cases were operated upon but a little over six months ago; in 2 the urine is at present free from albumin and casts, 1 other shows great improvement, and the fourth presents only slight evidences of renal disturbance. Three cases disappeared from observation within six weeks of the operation, and the time elapsed since operation of the last 2 cases is yet too short to warrant any deductions. The cure of the chronic nephritis is only initiated by the operation; it is thereafter gradual and progressive, the final disappearance of albumin and casts requiring as long as from one to twelve months.—*Med. Record*, Dec. 21, 1901.

F. Mortimer Lawrence, M.D.

THE RECOGNITION OF TUBERCULOUS PLEURISY.—It is well known that many cases of acute pleurisy are or become tuberculous, and that pulmonary phthisis has often followed what was at the time believed to be an attack of simple pleurisy. In a recent clinical lecture published in the *Semaine Medicale* (No. 48), Professor Dieulafoy has collected the evidence which has accumulated to the effect that a large percentage of cases of acute pleurisy attributed to catching cold are really tuberculous. He now urges that it is important to determine in every case whether or not tuberculous lesions are present. He reviews the various means by which a diagnosis of pleural tuberculosis can be established: (1) By recognizing the tubercle bacillus in

the effusion by the microscope, by cultivations, or by injections into the peritoneal cavity of rabbits; (2) by Koch's tuberculin injections; (3) by an adaptation of serum diagnosis, as employed in the Widal test for the recognition of typhoid fever; and (4) by cyto-diagnosis or the careful examination of the leucocytes present in the effusion.

He concludes in favor of the last method, and states that in simple pleurisy, such as is met with in heart disease, Bright's disease, etc., the fluid does not contain, at least in the earlier stages, either lymphocytes or polynuclear leucocytes, but almost exclusively large endothelial cells derived from the serous membrane by desquamation. In infective pleurisy caused by streptococci, pneumococci, the typhoid bacillus, etc., polynuclear leucocytes are met with abundantly, as well as large mononuclear cells. If lymphocytes are present they are less numerous, and endothelium is observed only exceptionally. On the other hand, in acute tuberculous pleurisy, lymphocytes and red blood corpuscles are exclusively present, polynuclear cells and endothelial flakes being absent.—*Brit. Med. Journal*, Dec. 28, 1901.

F. Mortimer Lawrence, M.D.

POST-SCARLATINAL DIPHtheria AND RHINORRHOEA AND OTORRHOEA.—Williams, of Sheffield, contends that children convalescing from scarlet fever, especially in hospital practice, are without doubt peculiarly susceptible to the invasion of the diphtheria bacillus; not only is the mucous membrane of the throat liable to become infected, but also that of the nose, and, to a lesser degree, the surfaces about the external auditory meatus excoriated by discharge from the ear. As the result of a careful bacteriological investigation of the cases of rhinorrhœa and otorrhœa occurring in scarlet fever wards of the Metropolitan Asylum Board's Convalescent Hospitals during a period of three months and a half, he reaches the following conclusions:

1. That it is advisable to cultivate all cases of rhinorrhœa—apart from that of the acute stage—and otorrhœa in scarlet fever cases, especially in hospital practice.

2. That bacilli, when found at all resembling the diphtheria bacillus, must, in the present state of our knowledge, be regarded as a modified variety of that organism, bearing in mind that their staining properties are often the only means of diagnosis available, the clinical symptoms in this class of case being for the most part absent.

3. That systematic isolation of these rhinorrhœas and otorrhœas is not only justifiable, but advisable.

4. That such isolation may be reasonably expected to reduce the post-scarlatinal diphtheria incidence.

5. That it is an open question whether such mild cases require antitoxin treatment.

6. That these discharges, unassociated with sore throats or symptoms, and therefore easily overlooked, may be the cause of the often unaccountable outbreaks and the persistence of the disease amongst school children.—*Brit. Med. Journal*, Dec. 21, 1901.

F. Mortimer Lawrence, M.D.

TYPHOID INFECTION WITHOUT TYPHOID FEVER.—Bacteriology has shown that the specificity of the infective diseases depends neither on their clinical

evolution nor on the lesions produced, but on the pathogenic agent, and has, therefore, singularly modified nosology. Typhoid fever is a striking example. Its well-defined clinical and pathological features appeared to furnish all that was necessary to constitute "a disease." But they have been shown to be but some of the effects produced by specific organism—Eberth's bacillus—which may infest the whole system or may attack a particular organ or tissue either at the time of the fever or years afterward, giving rise to the so-called complications and sequelæ. A further step, which the discovery of Widal's reaction has facilitated, is the recognition of the fact that a lesion may be produced by the typhoid bacillus quite independently of any illness such as typhoid fever. Thus, Dr. Cushing has recorded a case of cholecystitis in which cholecystotomy was performed and the typhoid bacillus was found in the gall-bladder, and in which blood gave the typhoid reaction, although there was no history of typhoid fever. The gall-bladder appears to be, like Peyer's patches, a site of election of the typhoid bacillus. Cases of lesions due to the typhoid bacillus without typhoid fever have been but rarely observed, but M. Kelsch has recorded a case of hæmorrhagic pleurisy in a tuberculous subject, M. Fernet a case of serous pleurisy, and M. Guinard a case of appendicitis. Intermediate cases have been described. Thus, M. Fernet has recorded a case of typhoid meningitis in which, during the whole course, the symptoms were those of meningitis, and in which the intestinal lesions found after death were very slight. Cases of general typhoid infection (typhoid septicæmia) without intestinal lesions have been described by several writers. Recent researches have shown that the typhoid bacillus may be simply a saprophyte and occur in the stools of healthy persons. Thus, in the case of the typhoid bacillus, as in that of other microbes, the simple "germ theory of disease"—that the invasion of the organism by the microbe determines the disease—must give way to a more complex conception. Predisposing causes are necessary. According to these causes, according to the state of the viscera, a general typhoid infection without intestinal lesions (typhoid septicæmia) or with intestinal lesions (typhoid fever), or a local typhoid affection, results.—*The Lancet*, Dec. 21, 1901.

F. Mortimer Lawrence, M.D.

ARTHRITIS OF PNEUMOCOCCIC ORIGIN.—Raw, of Liverpool, states that before, during or after an attack of pneumonia the pneumococcus may cause arthritis, abscess, cellulitis, peritonitis, empyema, meningitis, pericarditis, otitis media, salpingitis, endocarditis, and keratitis. From an observation of a large number of cases of pneumonia he is convinced that the pneumococcus is capable of producing very serious lesions in other parts of the body than the lungs. Arthritis occurred as a complication in 7 patients out of 817 cases of pneumonia—equal to about 1 per cent. Of these 7 cases, 4 recovered and 3 died. Curiously enough, his cases correspond almost exactly with those recorded by Continental observers, in that 6 were male and 1 female. In all 7 cases the pneumonia was right-sided, and the joints affected were all on the right side. This may be only a coincidence, but the fact is striking. He has observed also, in some cases of pneumonia, a slight redness and pain in the shoulder-joint of the side affected, which has subsided with the crisis. The joint affection may either precede the lung symptoms or follow the crisis, or develop intercurrently. In Liverpool alcohol seems to decide in

great measure the severity of the attacks and the prospect of recovery. The only treatment for arthritis is early evacuation of the pus, if it can be reached. It is just possible that many isolated cases of synovitis and arthritis occurring either during or after an attack of pneumonia, or even independent altogether of pneumonia, may be due to this organism, and it is suggested that the name "Frankel's bacillus" would be more suitable than "pneumococcus."—*Brit. Med. Journal*, Dec. 21, 1901.

F. Mortimer Lawrence, M.D.

THE WIDAL REACTION IN THE DIAGNOSIS OF TYPHOID FEVER IN CHILDREN.—Gershel reaches the following conclusions:

1. The main facts concerning the Widal reaction in children are the same as those that hold true for adults.
2. In 84 cases of typhoid fever in children, ranging from one and a half to fourteen years of age, 81 cases gave a positive result.
3. In 115 cases that were fevers other than typhoid, the positive reaction was never obtained.
4. The reaction did not occur later in children than in adults, as is claimed by some writers, but, on the other hand, somewhat earlier. However, we should not lay too much stress on this point.

5. The Widal test is of greater importance in children than in adults, owing to the frequent atypical character of the discharge in the former, and the greater frequency of cases resembling pneumonia and meningitis.

6. As pointed out by Morse, the reaction will be of service in establishing the frequency of typhoid fever in children.—*Med. Record*, Nov. 23, 1901.

F. Mortimer Lawrence, M.D.

THE ACTION AND DOSAGE OF DIPHTHERIA ANTITOXIN.—C. Sigmund Raue, of Philadelphia, contends that, when tissue changes have set in, remedies should be prescribed that correspond subjectively and objectively, *i.e.*, homœopathically, to the case. At the same time, the anti-diphtheritic serum should be used to check the process by neutralizing the toxins still circulating in the blood or forming in the fauces. The most conscientious adherent of homœopathy need not fear that this mode of procedure is irregular or that there will be any interference with the action of his remedies, for there is no remedial action in antitoxin to disturb drug action of any kind. He advises the dosage suggested by Park—*i.e.*, for very mild cases, 1000 to 1500 units for the first dose; moderately severe cases, 2000 to 3000 units; very severe cases, 4000 to 5000 units; laryngeal cases, according to their severity, 2000 to 5000 units. If at the end of twelve hours after the injection the inflammation is advancing, or if at the end of eighteen hours the inflammation has not clearly begun to subside, a second dose should be administered. A third dose may be required in rare cases at the end of twenty-four to thirty-six hours. For children under one year, one-third less than these doses is recommended. In order to get the best results, and in fairness to antitoxin, the injection should be given early.—*Medical Counselor*, Oct., 1901.

F. Mortimer Lawrence, M.D.

THE ANEMIAS OF YOUNG CHILDREN.—Geissler and Japha (*Jahrb. f. Kinderheilk.*, 1901, liii., 627) arrive at the following conclusions:

(1.) Alterations in the red corpuscles, especially in the occurrence of nucleated cells, are, even in children, pathological. On the other hand, in young children, the total number of leucocytes, as well as the percentage of lymphocytes, is increased.

(2.) The division of the infantile anemias according to the number of the leucocytes is unjustifiable, because polynuclear leucocytosis at least may be only temporary. It is necessary, therefore, to determine the proportion of the various leucocytes.

(3.) Splenic tumor cannot be employed as a means of differential diagnosis in anemia. It occurs in light, as in severe, anemias, and may be present even when there is no anemia.

(4.) There occurs in young, rachitic children a condition of the blood which shows all stages, from a slight diminution of the hemoglobin and of the red corpuscles to the occurrence of megaloblasts. The severest forms are regularly accompanied with the splenic tumor; therefore, they may be called anemia splenica. There is no ground, however, for considering this a specific or primary disease. Its prognosis is not unfavorable.

(5.) Under the term anemia pseudo-leukemia various different conditions have been grouped; a part certainly belong to the simple, severe, chronic anemias of childhood (anemia splenica), a part, perhaps, to leukemia. Whether, as individual descriptions seem to show, there is a disease in which a peculiar leukemic picture can finally go on to complete cure, further observations must show.—*Boston Med. and Surg. Journal*, Dec. 12, 1901.

F. Mortimer Lawrence, M.D.

THE PERSONAL FACTOR IN TUBERCULOSIS.—Dyce Duckworth (*Medical Press and Circular*) says that there are two pathogenic factors to be regarded in any case of tuberculosis, (1) the host, and (2) the infecting parasite. The younger pathologists are too apt to "reckon without the host." Physicians must consider the personal factor in disease. The modern doctrine that "scrofula is tuberculosis" the author absolutely denies, and maintains that it is possible to be scrofulous throughout life without becoming tuberculous. The essential character of scrofula is a textural vulnerability to all kinds of irritation, and especially to tubercular invasion. Persons of gouty predisposition are thereby largely immunized against tuberculosis, the offspring of the gouty manifesting none of the peculiar delicacies of the strumous. Tuberculosis, when it occurs in the gouty, makes little progress, as a rule, and tends to obsolescence. Many of the preventive procedures against tuberculosis must relate to the personal factor, and our duty is to fortify the host against invasion, as well as to intercept and destroy the invader. The author protests against the modern idea of "curing" tuberculosis. All that we can do is to place the patient in conditions favoring an arrest of the process.—*Med. Record*, Dec. 14, 1901.

F. Mortimer Lawrence, M.D.

A SIGN OF INFANTILE PNEUMONIA.—Weill (*Semaine Med.*, Paris, May 29, 1901) claims that pneumonia in young children can be diagnosticated from other diseases by the following sign, which he considers pathognomonic: This sign is the lack of expansion in the subclavicular region, independent of the site of the pneumonic lesion. With the child on its back, the chest exposed, and respiration regular, it is easy to note the difference in the expansion between the two sides. On placing the fingers over the subclavian region on either side, they are lifted as by a wave on the sound side, while on the other the lack of expansion is evident, even in the very first days of the disease. In pleurisy or pneumothorax the lack of expansion corresponds to the seat of the lesion, but in pneumonia it is invariably subclavicular.—*Boston Med. and Surg. Journal*, Dec. 12, 1901.

F. Mortimer Lawrence, M.D.

MONTHLY RETROSPECT

OF HOMCEOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY O. S. HAINES, M.D.,

with the collaboration in German literature of C. Sigmund Raue, M.D.

TALKS ON ELEMENTARY THERAPEUTICS—RELATION OF ARSENICUM ALBUM TO ACUTE NEPHRITIS.—I always feel that the natural trend of the arsenicum case of acute nephritis is toward the development of those kidney changes which we recognize as chronic parenchymatous nephritis, and which the pathologists show us, post-mortem, as the "large white kidney." It is not at all impossible that your case of acute nephritis which has occurred subsequent to an attack of scarlet fever will result ultimately in just such a chronic condition, and therefore arsenicum may be a valuable remedy to assist in the prevention of such a catastrophe.

There can be no doubt about the power of arsenicum to produce, in poisonous doses, pathological changes in the structures of the kidneys that are very analogous to the changes taking place there in nephritis. Arsenicum produced, during life: scanty urine, much albumin, many tube-casts, much renal epithelium, some blood corpuscles, marked reduction in the excretion of the solids; and, death having resulted in a condition of coma, the victims were posted. The kidneys were found enlarged and hyperæmic.

Now, very extensive experiments have shown that arsenic affects particularly the epithelial structures of the body. These become shrunken and degenerated after a time. We know how likely it is to produce cedema, and it may go so far as to produce a general anasarca, as has been seen in cases that have taken what were supposed to be medicinal doses for a length of time. Associated with all these pathological changes there is ever much prostration and great physical weakness and debility; and the anæmic appearance of such a patient will amount to a cachexia.

Now, when we add to all these effects its action upon the mucous and serous membranes, its weakening influence upon the heart muscle, and its effects upon the nervous centres, we almost come to the conclusion that arsenicum will prove to be a specific for nephritis. But clinical experience shows that it is only efficacious in a limited number of cases of this disorder; and careful investigation reveals that it is only effective when there is present a certain well defined and distinct picture expressed to us in symptoms and signs, and which, taken all in all, is known to us as the "arsenic picture." When this familiar ensemble of symptoms and signs is present, the arsenic may be expected to cure, if the case be a curable one; or ameliorate, if there be not some mechanical factor present that prevents a vital response to the potentized medicament. This latter statement of mine needs a little

further explanation. Take, for example, a man suffering from a typical arsenic dyspnoea, but who has, at the same time, such an accumulation of ascitic fluid within his abdominal cavity that its pressure upon his diaphragm, heart and lungs renders relief by any potentized medicament impossible within a reasonably short time. In such a case, the mechanical expedient of tapping places his organs in such a condition that we may expect some effect from our remedy. Otherwise, arsenic or any other potentized remedy may fail to relieve.

So, after all our pathological deductions, you perceive that we have come back to our plan of learning the individuality of our remedy before we can use it, in practice, with any certainty or satisfaction.

Let us begin by saying that the arsenicum case of acute nephritis will be one that is dragging along, that is surely tending toward chronicity and the development of those serious kidney changes which mark the parenchymatous nephritis. There has been a marked decrease in our patient's strength; he has become pale, waxy, and anæmic. His urine is scanty, contains much albumin, many tube-casts, and some of them are granular ones; if there be blood, it will be quite small in amount, nor would we lay much stress upon the symptom of painful micturition. There may be pus in the urine as well. The excreting powers of the kidneys have diminished.

Now, in a case in which the above facts are prominent and known to us from our examination of the case, it may be that the first symptom that will direct our minds to the arsenicum will be the fact that the patient exhibits a great degree of *restlessness*. Not the restless movement that can be traced to a state of nervous tension such as we witness under aconite, nor yet the constant, restless change of position that comes from much bodily discomfort, such as we have learned was so prominent in the rhus condition. It is the mental and physical restlessness that drives one from place to place, that prevents rest anywhere, that fills the mind with anxiety, fear and horror, and which causes the poor sufferer, even although he be prostrated almost to death's door, to throw his arms and limbs about the bed, and cry out, as if in a frenzy, "I must get up," "I must move."

Now, should such a patient have difficulty in breathing, the added restlessness and anxiety of arsenicum will produce a frightful picture of a man sitting upright in his bed, his anxious face bathed in sweat, in a perfect frenzy of fear of suffocation, begging to be allowed to rise for no other reason than that he feels that unless he moves he will die.

It is curious, but true, that many of the sufferings of the arsenicum patient are aggravated at or about *midnight*. This is commonly the time of greatest suffering from dyspnoea or shortness of breathing. Such a condition as I have outlined, occurring at the time of aggravation, would strengthen our choice of this remedy.

Then, again, such a case will generally have extensive dropsy. His limbs, pale, waxy and cold, will be so œdematous that pressure of finger will leave a depression for some moments afterwards.

And again, with all, he most certainly will have an *intolerable thirst*; he will continually ask for cold water. You may use your own judgment in regard to the temperature of the water offered him, for very *cold* drinks do not set well upon the arsenicum stomach, although they are momentarily grateful to the patient.

Thus we see that the restlessness, the difficulty in breathing, the extensive dropsy, the extreme thirst, when combined with the evidences of great weakness and prostration and serious kidney changes, would make us think very strongly of the arsenicum for a case of acute nephritis.

But that is not all. We have said that cold drinks do not agree with the arsenicum stomach. Neither does cold food, nor any kind of food, for that matter, unless, perhaps, it be *warm* food or drinks. So great is the irritability of the stomach in the arsenicum condition that vomiting is almost continual.

Add this to the constant *burning*, feelings of *pressure*, and sensitiveness to touch that are present in the stomach, and you can remember these as the elements of the stomach picture that call for the remedy. Now, in nephritis we frequently have much trouble with these stomach symptoms, and we often have to prescribe arsenicum for their relief.

The heart weakness of arsenicum, often present in nephritic cases, is a cause of much alarm to the physician. It is natural that the heart should participate in the general prostrated state which is characteristic of arsenicum, but often I think the heart condition must be one of more serious degeneration in the muscular walls of the organ. We find the pulse *small, rapid and weak*, and generally a diminished arterial tension. When such a pulse is associated, as it not infrequently is in nephritis, with a cough, worse at night, suffocative spells, that come on towards midnight, and wheezing, rattling sounds over the bases of each lung, with difficult expectoration of frothy, white mucus, we say, look out for pulmonary oedema; and our thoughts turn to arsenicum stronger than ever. So, you see, there are many groups of symptoms that *may* lead us to the recognition of the whole arsenicum picture.

AS THROUGH A GLASS, DARKLY.—Dr. Herbert T. Webster, M.D., standing a long way off, and looking through his eclectic glass, thus discerns homœopathy and homœopaths: "The only system of therapeutics extant at the present time worthy of recognition is the homœopathic, and it is so fallible, practically, that its devotees wander outside the lines laid down by its founder more than half the time. Their practitioners are trying, changing and alternating remedies constantly; usually every day, in acute cases, in order that they may stumble onto the 'similimum.' In other words, they try, hit or miss, until they hit the lucky remedy."—(*American Med. Journal*, January.) Come up closer, brother; the view is much better.

ZINCUM METALLICUM IN PERIODIC HEADACHE.—Dr. Mossa recites the following case in *Allg. Homœopathische Zeitung*, Dec. 5, 1901: A young man, æt. 19 years, anæmic, was suffering from the effects of an attack of influenza that had attacked mainly the nasal mucous membrane. He was an optician by profession, and had strained his eyes in setting delicate telescopic lenses. The frontal sinuses were affected, and since a week a severe headache developed regularly at 10 A.M., remaining until 4 P.M., after which complete relief set in. The pain is throbbing in character, isochronic with the pulse, and begins in the occiput, whence it spreads over the vertex to the supra-orbital region. There is constipation and slight indigestion.

During the attack, the patient is obliged to lie down and keep the eyes

closed; opening the eyes aggravates the symptoms. Zinc. met. 6 trit., 3 grs. night and morning, promptly dispelled the attacks.

Dr. Mossa further remarks the zinc specifically a brain remedy, and quotes several cases in which it was prescribed with success on the organo-therapeutic principle. He, however, advises a close study of its symptomatology, and believes the best results are obtained when prescribed strictly according to the law of similars.

PHOSPHORUS IN POST-DIPHTHERITIC PARALYSIS.—In a paper read before the Society of Homœopathic Physicians in Stuttgart (*Verein Hom. Aärzte Stuttgart*), Nov. 14, 1901, Dr. A. Stiegele recited the following cases:

A man æt. 41 years had an attack of diphtheria in May, 1901. He was first seen by the writer August 21st, at which time there was marked debility of the extremities; slow, uncertain gait; attacks of cardiac palpitation. There had been paralysis of the vocal cords, which disappeared under electrical treatment. The patient complained of formication in the hands and feet.

Phosphorus 5th dilution was prescribed, and in a few days the formication disappeared, followed in a short time by improvement in the other symptoms. Three weeks after beginning the treatment he was able to resume work on the farm. Judging from the short time improvement set in after the administration of phosphorus, there seems to be no doubt that the remedy acted promptly and beneficially, and that the course of the disease was materially affected thereby. Anyone who has observed the slow course of this malady will concede that point, and reference to standard old-school works teaches how little is to be expected from the routine treatment with strychnine.

Dr. Stiegele says that the indications upon which he prescribed phosphorus in this case, "post-diphtheritic paralysis with formication in the hands and feet," are on the recommendation of Dr. Cochran. In Hering's condensed "*Materia Medica*" we find: "Paralysis—formication and tearing in limbs. Finger-tips feel numb; hands and feet numb; clumsy. When walking makes missteps from weakness."

PILOCARPIN HOMŒOPATHICALLY PRESENTED.—Dr. Man reports the following case (*Leipziger Pop. Zeitschr. für Hom.*): Mrs. B., æt. 25 years, four months pregnant. Since several weeks nausea and greatly increased secretion of saliva. Often vomits large quantities of saliva and mucus. Anasarca of the feet and genitals. Pilocarpin 6x every three hours. In a few days salivation, vomiting and anasarca completely disappeared.

Pilocarpin has also been successfully employed in profuse sweating, to which condition it is truly homœopathic.

AURUM IODATUM, says Dr. J. B. Garrison, has been found to give excellent clinical results when given for the removal of deposits upon structures, as in chronic pericarditis, valvular diseases, etc.—*N. A. Jour. of Hom.*

TREATMENT OF INFANTILE SCURVY.—The diet must be radically changed. Raw milk, sieved potato, fresh fruit juice, as that of the orange, and the juice of rare steak. Calcareous phosphorus and silica are most often indicated.—G. H. Jenkins, M.D., in *N. A. Jour. of Hom.*, Dec.

VERATRUM VIRIDE.—We cull the following case from the pages of that admirable little eclectic journal, *The Medical Gleaner*: Dr. G. F. Severs was called one evening to see a nervous, undersized, two year old girl, who had measles. Her temperature was 104° , and she was in convulsions. The doctor says: "I never saw such convulsions." It was at first necessary to give the child chloroform until complete anæsthesia was produced. After awhile he allowed her to recover consciousness, and back came the convulsions as severe as before. Then he administered, hypodermatically, three drops of veratrum viride (the specific tincture) in a syringeful of water. Within three minutes she was limber and resting easily. No more convulsions occurred, and next morning her temperature was normal, and the eruption of measles was fully out. The family physicians who are brought face to face with such cases as this one must have been will not fail to see the point of this story, and will doubtless appreciate the prompt effect of the remedy.

THERAPEUTIC HINTS FROM ECLECTIC SOURCES.—The *Eclectic Medical Journal* for November contains, among other therapeutic suggestions, the following: Dr. Lee Strouse has observed the following therapeutic effects from conium maculatum: In a case of paralysis (variety not mentioned) from injury, he gave the patient a mixture which contained 20 drops each of nuxvom. and conium. Of this four-ounce mixture, the man took a teaspoonful four times a day and was cured. The patient increased in strength, the paralysis improved rapidly, and nocturnal pains, which had been very annoying, ceased. After a time the amount of the remedies was increased to 1 drachm of each tincture to 4 ounces water.

Another patient, a brakeman, had been very seriously injured (nature of his injuries not stated) by falling from a freight car. After two years, he could scarcely crawl along with assistance of two canes. Above treatment has worked a marvellous improvement. The doctor believes that persistent, dull, aching pains are relieved by conium, especially when the patients are despondent and believe that they are suffering from some serious ailment. Twenty drops to four ounces water, in teaspoonful doses every two hours, will give relief quickly.

In aged patients, who suffer from gouty or rheumatic conditions, with ever increasing pain and discomfort, this remedy may be depended upon to afford quick relief. In constitutional syphilis, the pains and persistent aching are relieved by this remedy. So, also, in cancer of the stomach, with distress and pain; the author believes that the remedy will check the disease as well as give relief to suffering. There can be but little doubt that such observations as the above are of great value, although they have been made from a purely clinical standpoint; yet their value, as reported, is much vitiated because of the lack of clinical and pathological details. One can hardly make use of such data in practice. The sphere of the action of conium has not been made sufficiently clear. This is unfortunate, because clinical observations are second only in importance to the results obtained by systematic and scientific drug proving.

HORSE SENSE.—"I have nothing to say against physicians experimenting along the line of glandular extracts, but for heaven's sake do not inject cerebrine from a horse into your patients, or they will know more than yourselves."—J. T. Blank, M.D., *Eclectic Med. Journal*.

INFANTILE SCURVY.—“I remember a case of my own in which I tried very diligently to afford relief, and after using many other remedies ineffectually, it yielded nicely to the simple *juice of the grape*, administered several times each day.”—C. A. Ward, M.D., *Medical Century*.

KALI BICHROMICUM IN LARYNGEAL AFFECTIONS OF INFLUENZA.—During this year's epidemic of influenza in Leipzig, laryngeal symptoms were prominent, and were mostly benefited by kali bichromicum. (Walper.)

MERCURIAL INUNCTIONS IN SYPHILIS.—This method of treatment in syphilis was discussed at the Generalversammlung des Hom. Centralvereins Deutschlands, convening in Frankfurt, Aug. 10, 1901. Dr. Walper stated that in serious bone affections we cannot dispense with inunctions (carried out in a mild form) if we wish to avoid disfigurement and deformity. Dr. Gisevius, Jr., emphasized the fact that Dr. Dahlke, a recognized advocate of higher potencies, did not lay aside inunctions in syphilis. Dr. Göhrum claimed good results from high dilutions.

POTENTIZED ANTITOXIN SERUM IN DIPHTHERIA.—Dr. Kirn (*Allg. Hom. Zeitung*) claims to have obtained good results from antitoxin serum administered in potency in diphtheria. In very severe cases he used it hypodermatically, apparently in a diluted form.

CONCERNING THE ACTION OF PSORINUM.—Gisevius (*Allg. Hom. Zeitung*) considers the action of *psorinum* unreliable, as the preparations were made from infected itch lesions. He seems more inclined to accept *bacillinum* (Burnett) as a representative remedy. We wonder if the doctor has a good preparation of *psorinum*, and would like to ask what is the difference between an infected skin lesion and a suppurating lung area. Pus is pus, at least in the majority of cases, and we fear there are precious few tubercle bacilli in *bacillinum*, and just as many cocci as in *psorinum*.

SULPHUR AURATUM ANTIMONII.—This remedy was well spoken of by Dr. Goullon (*Envoy* for Nov., 1901) for its beneficial effects at the conclusion of an acute laryngeal or bronchial catarrh, or even in the subacute form of these ailments. It loosens the cough beautifully, and the coarse, hoarse voice soon regains its timbre. Of course, Dr. Goullon does not deny the efficacy of such remedies as phosphorus, spongia or bromine; but these latter remedies have their spheres well defined, as every homœopath knows. If, however, you come across a “cougher” who can find *no rest* from coughing, either day or night, whose throat and chest are *very sore* from coughing, he will likely obtain the much desired relief from as much of the golden sulphur as will lie upon the point of a knife-blade, given four times a day, and also at night. We must add, for completeness, that Dr. Goullon prefers to use the first centesimal trituration.—*Hom. World*.

EUCALYPTUS GLOBULUS AS A PROPHYLACTIC.—Dr. Frederick Kopp, Greenwich, N. S. W., has demonstrated to his own satisfaction that the eucalyptus has the power of preventing the spread of influenza. He gives 3 minims of the tincture four times daily, and claims that those who take the remedy will not contract the disease, although constantly brought into contact with members of their families who are suffering from influenza in an aggravated form.—*Hom. World*.

PURE WATER.—Nature's universal aseptic; it muddles no brains, it fills no asylums or prisons, it begets no anarchy, but sparkles in the dewdrop, glows in the peaceful rainbow, and flows in the river of life close by the throne of God.—(Nathan Smith Davis, in *American Physician*.) If our pure water commission would only go and investigate this matter, something might be accomplished.

PHASEOLUS NANA.—Dr. Frank Kraft tells how he was sitting on the porch of the hotel last summer, in conversation with Dr. A. M. Cushing, while the American Institute was holding its annual session; conversation drifted to the subject of certain very troublesome forms of heart disease. Dr. Kraft mentioned the case of an elderly gentleman, a steamboat captain, an over-user of tobacco, who had suffered from rheumatism and had been in a sanatorium. Latterly Dr. Kraft had sometimes been at a loss for a remedy which would quickly relieve his "heart spells," which were severe and accompanied by suffocative paroxysms. Dr. Cushing suggested a trial of the phaseolus nana. When Dr. Kraft returned home from the meeting the captain had several violent attacks, and was once given up for lost. The administration of this remedy in the 25th potency helped the patient so much, that in a few hours he was able to be about with comfort, and could lie upon either side—like an expert attorney. This remedy is the tincture of the common white bean, introduced to our notice as a remedy for serious heart troubles by Dr. Cushing, to whom also we owe rhatanhia. A careful study of the pathogenesis of phaseolus will repay one. We are sorry Dr. Kraft did not tell us more about the exact condition present in the case he mentions.—*The American Physician*.

THERAPEUTIC HINTS FROM THE NEW HOMŒOPATHIC JOURNAL OF PEDIATRICS.—It gives us much pleasure to welcome the new journal devoted exclusively to the subject of pediatrics. If one may judge from its first number, it is going to be a splendid little journal, well edited, beautifully printed, and full of just those things which will be of the greatest interest to every physician who treats children. The leading article this month is from the pen of our own Bigler, who calls attention to the fact that, contrary to the belief which seems to prevail, a child "has nerves," and that its nervous system makes certain imperative demands upon the attention of the parents and the family physician which cannot be disregarded without serious detriment to its present and future healthy development.

Natrum muriaticum, says the editor, is an excellent remedy for the fresh colds of children. The discharge from the nose is as clear as water; there is sneezing, together with watering of the eyes or excessive secretion of saliva. A few doses of *natrum mur.* 6x will cause a disappearance of such symptoms. The same remedy will help many beginning colds in adults, and is often forgotten.

Petroselinum is a very effective remedy for a frequency of micturition, the desire for which comes on very suddenly; and, if not attended to at once, causes quite severe pain. The child dances up and down and begins to cry every time this desire to urinate comes on. This condition is common; try it.

Hydrastis is an admirable remedy in the treatment of constipation of infants, especially so when the constipation, because of its long standing, has

been the means of producing other ailments. It may, however, be useful when constipation is the only symptom. The *hydrastis* child, if old enough, will complain of a heavy feeling in the epigastrium; the skin may have a yellowish tinge, there may be tenderness in the region of the liver; the stools will be light colored, also hard and lumpy, and mixed with mucus. If the child has become debilitated from the continued use of laxatives, so much the better will the remedy be indicated. As useful and harmless adjuvants may be mentioned the occasional use of a suppository made of gluten; and systematic gentle massage of the abdomen, in the line of the ascending, transverse and descending colon. *Natrum muriaticum* is a remedy that should be studied for those tedious cases of infantile constipation in which the child never has the slightest inclination for an evacuation, unless assisted mechanically.

"SOMETHING IS ROTTEN IN THE STATE OF DENMARK."—The eminent Dr. Oscar Hansen, of Copenhagen, Denmark, contributes to the *Homœopathic World* some interesting cases from his practice. He mentions the fact, as he proceeds, that "Since the year 1886 we have lost the right of dispensing our own medicines, and must always prescribe from the chemist's lower dilutions, and always in drop doses." It is to be hoped that the grandmotherly government also exercises a supervision over the methods used by the "chemists" in the preparation of the homœopathic tinctures and dilutions.—*Hom. World*.

POISONOUS EFFECTS OF BORACIC ACID.—Rhinehart (*Therap. Gaz.*) mentions 2 cases in which the administration of what are supposed to be medicinal doses of boracic acid was followed by severe symptoms. The cases would probably have died if the cause of the alarming symptoms had not been discovered. In the first case, a man aged 38 years, five-grain doses of boracic acid every four hours were followed within two days by an erythematous rash, beset with papules and vesicles, upon the backs of the hands and between the fingers. Pulse became weak, but not accelerated. Patient became collapsed. These symptoms subsided slowly upon withdrawal of the drug, but reappeared on resuming it.

Case two, man aged 50 years, had his bladder washed out daily with a saturated solution, and took internally five grains every fourth hour. Ten days after beginning this treatment an erythematous rash appeared, with scales and crusts. The skin thus affected became thickened and infiltrated, as in an eczema. Albuminuria and weakness were prominent symptoms. The pulse was feeble and nausea was present. The temperature rose two degrees above normal, at the height of the eruption.—*Hom. World*.

DIABETES INSIPIDUS CURED BY LYCOPodium.—This affection is sometimes troublesome, as many physicians will agree. The following case, reported by Dr. Berlin, in the *Leipziger Pop. Z. f. Hom.*, and translated for our excellent *Hom. Recorder*, will therefore be interesting: Diagnosis, diabetes insipidus; urine, eight quarts in twenty-four hours, pale as water; specific gravity, 1004; no albumin, no sugar. The patient was very thirsty, felt weary and wretched. Increase in the appetite. Considerable emaciation. *Lycopodium* 30, three drops morning and evening, cured the patient.

THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER.

A Medical Newspaper.

EDITED BY

HERBERT P. LEOPOLD, M.D.

FEBRUARY, 1902.

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American Edition of Nothnagel's Encyclopædia—Variola, Vaccination, Varicella, Cholera, Erysipelas, Whooping Cough, Hay Fever. Variola (including Vaccination). By Dr. H. Immermann, of Basle. Varicella. By Dr. Th. von Jürgensen, of Tübingen. Cholera Asiatica and Cholera Nostras. By Dr. C. Liebermeister, of Tübingen. Erysipelas and Erysipeloid. By Dr. H. Lenhart, of Hamburg. Whooping Cough and Hay Fever. By Dr. G. Sticker, of Giessen. Edited, with additions, by Sir J. W. Moore, B.A., M.D., F.R.C.P.I., Professor of the Practice of Medicine, Royal College of Surgeons, Ireland. Handsome octavo volume of 682 pages, illustrated. Philadelphia and London: W. B. Saunders & Co. 1902. Cloth, \$5.00 net; Half-morocco, \$6.00 net.

Interest in this volume of Nothnagel's Encyclopædia is at once enhanced when one learns that the editor of the American edition is Dr. J. W. Moore,

who, a number of years ago, wrote a most valuable book on the Continued and Eruptive Fevers. Moreover, the volume becomes of especial interest at the present time because of the epidemics of small-pox prevailing in various portions of the country, the consideration of which disease, together with vaccination and varicella, takes up nearly one-half the volume.

The other articles, each by a German specialist of recognized authority, are also skillful expositions of the particular diseases under discussion. The entire volume being edited by a specialist of acknowledged ability, the work, it will be seen, has been brought precisely down to date. It is, indeed, a magnificent contribution to the literature of medicine.

Although the excellence of the German work and the detailed and comprehensive manner in which the respective authors have dealt with their several subjects left comparatively little to be added, the editor has not hesitated to amend the text whenever necessary, and has also embodied the results of his personal experiences, gained during a varied practice extending over thirty three years.

Lea's Series of Pocket Text-Books. Venereal Diseases. A manual for students and practitioners. By James R. Hayden, M.D., Chief of Clinic and Instructor in Venereal and Genito-urinary Diseases at the College of Physicians and Surgeons (Columbia University), New York; Assistant Visiting Genito-urinary Surgeon to Bellevue Hospital. Third and revised edition. Illustrated with sixty-six engravings. Philadelphia and New York: Lea Brothers & Co.

Although classed as a pocket text-book, this work is far more than its name implies, for it presents in its nearly 300 pages a practical working knowledge of gonorrhœa, chancre, syphilis and stricture. The author's style tends strongly to brevity of expression, and this enables him to say things in less time and with more positiveness than is the case with many writers. The reader is, therefore, not left to guess at the ideas intended to be conveyed.

Jonathan Hutchinson, F.R.S., General Secretary of the New Sydenham Society, has requested Messrs. P. Blakiston's Son & Co., of Philadelphia, the American agents of the Society, to announce the publication of "An Atlas of Clinical Medicine, Surgery and Pathology," selected and arranged with the design to afford, in as complete a manner as possible, aids to diagnosis in all departments of practice. It is proposed to complete the work in five years, in fasciculi form, eight to ten plates issued every three months in connection with the regular publications of the Society. The New Sydenham Society was established in 1858, with the object of publishing essays, monographs and translations of works which could not be otherwise issued. The list of publications numbers upwards of 170 volumes of the greatest scientific value. An effort is now being made to increase the membership, in order to extend its work.

P. Blakiston's Son & Co. announce as nearly ready "Clinical Hematology," a Practical Guide to the Examination of the Blood with Reference to Diagnosis. By John C. DaCosta, M.D., Assistant Demonstrator of Clinical Medicine, Jefferson Medical College; Dermatologist to the German Hospital, etc.

Personals.—Mr. and Mrs. Henry A. Weldy announce the marriage of their daughter, Kate Gertrude, to Dr. George Wogan Hursh, January 1, 1902. They will reside in Columbia, South Carolina.

Dr. Gustave A. Van Lennep has returned from his wedding tour through California, and has resumed practice at 1516 Chestnut Street, Philadelphia.

Dr. and Mrs. O. S. Runnels announce the marriage of their daughter,

Agnes McCulloch, to Mr. Hugh H. Hanna, Jr., December 31, 1901, Indianapolis, Indiana.

Dr. and Mrs. David P. Butler announce the marriage of their daughter, Alice Cary, to Dr. Daniel E. Chase, Jr., January 6, 1902, at Boston, Massachusetts.

Dr. B. K. Wilbur, of Ardmore, Pa., announces his retirement from practice.

Dr. Charles Caleb Cresson, H. M. C. '55, of 5009 Green Street, Germantown, died January 8, 1902.

Dr. Francis Edmund Boericke, H. M. C. '63, a member of the firm of Boericke & Tafel, Pharmacists, residing at 6386 Drexel Road, Overbrook, Pa., died December 17th, 1901, at the age of 75. The doctor is survived by his widow and nine children.

The Maltine Company are offering one thousand dollars cash for the best essay on preventive medicine. Full particulars may be found in their advertisement on page vii. of this journal.

New York Letter.—The New York Homœopathic Materia Medica Society held its annual meeting at the residence of Dr. G. F. Laidlaw, 58 West 53d Street, on the evening of December 18th. The following officers were elected: *President*, Dr. Walter Sands Mills; *Vice-President*, Dr. Willard Ide Pierce; *Secretary* and *Treasurer*, Dr. Charles Ver Nooy; *Collaborator*, Dr. William H. Dieffenbach. The topic of the evening appointed for discussion was "Mercurius." Dr. E. D. Simpson introduced the subject, and the remedy was discussed by all the members present.

The meeting of the Academy of Pathological Science was held at the residence of Dr. G. F. Laidlaw, 58 West 53d Street, on the evening of December 27th, the president, Dr. Laidlaw, in the chair. Drs. V. A. H. Cornell and F. W. Cornwell were elected to membership. The following subjects for discussion were presented: by Dr. S. F. Wilcox.—Specimens: *a.* Daughter cysts and hooklets from hydatid cyst of liver. *b.* Uterine fibroid with attachments to the omentum. *c.* Large Prepatellar Bursa. *d.* Large Bursa of elbow. *e.* Racemose glandular tumor of breast. *f.* Cysto-Sarcoma of Scapula. By Dr. W. H. Van den burg.—Dare's Hæmoglobinometer. Two cardiac cases. Patients presented. By Dr. W. S. Mills.—Brain of hemiplegic. Discussed by Dr. J. E. Wilson. By Dr. G. F. Laidlaw.—Scirrhus of œsophagus. Patient presented. Discussed by Dr. G. W. Roberts.

Dr. James W. Ward, of the Homœopathic Hospital College of San Francisco, was a guest, and discussed the case of sarcoma presented by Dr. Wilcox.

The usual collation was served at the close of the meeting.

The Homœopathic Medical Society of the County of New York held its regular meeting on the evening of January 9th, President Van Den Burg in the chair. Six new members were elected. A special committee presented a report in memory of the late Dr. Henry Clark Houghton, whose death was reported in the January HAHNEMANNIAN.

The retiring president, Dr. L. L. Danforth, delivered the annual address. His title was, "The Early History of Homœopathy in New York—a Retrospect and a Forecast." The paper was one of great interest, and contained a fund of information regarding the early practitioners of homœopathy in New York City. By unanimous vote the address was ordered printed for distribution.

The new president, Dr. Wm. H. Van Den Burg, delivered his inaugural address. It dealt mainly with the policy of the new administration for the coming year. The recent election of officers in the County Society was one of the most hotly contested in years. The canvass was carried on strenuously from

the time of nomination until the last vote was cast. The vote was close and the officers elected had a scant majority. Now everybody is united and it is expected that things will boom.

There was one scientific paper presented. Dr. E. D. Simpson spoke on "Mental Therapeutics." Dr. Simpson believes that in "Suggestion" the physician has a powerful adjunct in the treatment of disease.

The regular meeting of the New York Pædological Society (Homœopathic) was held at the residence of Dr. G. H. Laidlaw on the evening of January 15th. Prof. J. S. Adriance, Professor of Chemistry at the New York Homœopathic Medical College and Hospital, gave a lecture on the composition of human milk and of cows' milk. He spoke at length on the proper proportions of food elements in the modified milk-feeding of infants. Prof. Adriance has been called upon to analyze the food of many infants that were not properly nourished. His observations lead him to the conclusion that the percentage of proteids is the thing to watch. The fats and carbohydrates are tolerably constant, and need no special supervision. The talk was very instructive, and Prof. Adriance did not agree altogether with text-book authorities on proper infant feeding.

Dr. Egbert Guernsey has been quite ill for several weeks.

Dr. Martin Deschere has announced his retirement from practice for the present. He proposes to cease all professional work for at least one year. Dr. Deschere has been quite ill and confined to his room for several weeks.

Dr. William E. Rounds has taken charge of the practice of the late Dr. Henry C. Houghton.

Dr. Wilfred G. Fralick has ceased to be a member of the Medical Board of the Metropolitan Hospital.

The Flower Hospital received a number of the victims of the Park Avenue tunnel disaster of January 8th. Two of them have died.

Brooklyn Letter.—The regular monthly meeting of the Kings County Homœopathic Medical Society was held on the 12th inst.

Dr. Moffat, the Necrologist, reported the death of Dr. W. E. Hudson. Dr. Hudson was a veteran of the Civil War, and a thirty-second degree Mason. He was an invalid for some time, but the loss is none the less. The Doctor was a graduate of the New York Homœopathic Medical College. The death of Dr. S. E. Styles was also reported. He had been a practitioner since 1870; he was a thirty-second degree Mason, and an active church official.

Dr. Ritch's motion to provide a repository for papers read before the Society was adopted.

Dr. Ritch read a paper on "Gunshot Wounds." President McKinley's case was presented, and the opinion expressed that the poor physical condition of the patient, together with the bruising incidental to penetration of ball, were responsible for gangrene.

Dr. Robinson read a report of a "Case of Ruptured Tubal Pregnancy." The shock at the time of the rupture was intense, but the patient was operated, only to die, after a long fight for life, from heat prostration.

Dr. Searle, in discussion on the nausea and vomiting from which this patient suffered, said he did not believe that Homœopathy was indicated in reflex symptoms.

Dr. Charles Lewis Bonnell, of 3 Hanson Place, Brooklyn, died January 15th. He had been ill in bed but a little over two weeks. Dr. Bonnell was a graduate of Wesleyan University, Class of 1858, and of the Hahnemann Medical College of Philadelphia, Class of 1871. Dr. Bonnell was for many years one of the surgeons of the Brooklyn Homœopathic Hospital. At the time of his death he was also consulting surgeon to the Memorial Hospital of Brooklyn.

He was a member of the Homœopathic Medical Society of the County of Kings, of the Homœopathic Medical Society of the State of New York, and of the American Institute of Homœopathy.

Ralph L. Lloyd, M.D.

The Hahnemann Hospital Report for December, 1901.—The report of the Staff for December, 1901, gives the following summary of cases treated:

In-patient Department: new patients admitted, 115; old and new patients treated, 204; pay patients, 60; free patients, 144; aggregate days patients in hospital, 2856; average days each patient in hospital, 14; prescriptions, 1446.

Out-patient Department: new patients treated in the emergency wards, 997; new patients registered, 1616; visits of all patients, 6943; visits of patients treated at home, 206; patients treated at home, 62; prescriptions, 4073.

The Fourth Annual Meeting of the Washington Homœopathic Society was held on Dec. 13 and 14, 1901, at the Hotel Willard. The following programme was carried out, and the meeting proved the most successful of any since the establishment of the society:

Programme, Friday Night, Red Parlors.—"Apis Mellifica," Alice Burritt, M.D.; Discussion, Julia M. Green, M.D. "Some Gynæcological Remedies," W. R. Andrews, M.D.; Discussion, M. A. Custis, M.D. "A Few Remarks Concerning Iron," Eldridge C. Price, M.D., Baltimore; Discussion, Richard Kingsman, M.D. "Cheneline in Anæsthesia," W. G. Emery, M.D.; Discussion, C. L. Bliss, M.D. "Nux and Sepia in Sleeplessness," C. B. Gilbert, M.D.; Discussion, B. F. Gibbs, M.D.

Programme, Saturday Night, Banquet Hall.—"The Surgical Uses of Paraffin Injection," R. S. Copeland, M.D., Ann Arbor; Discussion, Henry Krogstad, M.D. "Disease of the Nasal Accessory Cavities," R. S. Copeland, M.D.; Discussion, L. Y. Baker, M.D. "A Consideration of Some Varieties of Glandular Enlargements from a Medical Standpoint," Clarence Bartlett, M.D., Philadelphia; Discussion, M. M. Moffitt, M.D. "Appendicitis Complicating Pregnancy," W. B. Van Lennep, M.D., Philadelphia; Discussion, Macpherson Crichton, M.D.

Following the papers and discussions on Saturday evening, the President, Dr. Z. B. Babbitt, in the name of the Society, thanked Drs. Van Lennep, Bartlett and Copeland for their adding so much to the enjoyment and entertainment of the evening, and a collation was served and enjoyed by all.

The regular monthly meeting of the Washington Homœopathic Medical Society was held at the Hotel Willard on January 7, 1902, and the following officers were elected for the ensuing year: *President*, G. W. M. Custis, M.D.; *Vice-President*, L. B. Swormstedt, M.D.; *Secretary*, A. H. Taylor, M.D.; *Treasurer*, H. H. Hawxhurst, M.D.; *Censors*, Dr. M. H. Moffitt, Dr. I. R. Dennison, Dr. C. B. Gilbert, Dr. Alice Burritt, and Dr. E. S. Lothrop.

Dr. George E. Lewis, of the Southern Homœopathic Medical College, 1901, was elected to membership.

The various annual reports were presented and several minor changes made in the constitution and by-laws.

The subject for the February meeting was made "Uricacidæmia in Relation to Eye and Ear Disease," and Dr. Woodward was placed in charge of the bureau.

Drs. C. L. Bliss and J. W. Branson have been elected to the Visiting Staff of the National Homœopathic Hospital, vice Drs. Richard Kingsman and W. F. Corey, resigned.

Dr. W. F. Corey and Dr. Z. B. Babbitt have resigned from the Washington Medical and Surgical Club.

Dr. Lee, who has been ill for some months past, is again able to attend to his practice. Dr. Davis has been in attendance.

The Hygienic Laboratory of the Marine Hospital Service will soon be erected, the \$36,000 authorized for this purpose to be expended on its establishment having become available, and the contract is about to be let.

Mortuary Statistics.—For the year ending June 30, 1901, there were 6087 deaths in the District. 3430 white and 2657 negro. The annual death-rate was 21.83 per 1000: for white 17.82, and for negro 30.73. Both rates are in excess of those for the preceding year. The report urges the desirability of medical inspection of the public school children.

William A. Warfield, M.D., Washington, has been made surgeon-in-chief at Freedman's Hospital, vice Austin W. Custis, M.D., resigned.

Hospital for Foundlings.—The Secretary of the Interior has recommended to Congress an appropriation of \$6000 for the maintenance of the Washington Hospital for Foundlings.

To Aid the Blind.—The Board of Charity has recommended to the District Commissioners that the Aid Association for the Blind be compensated at the rate of \$10 per month for blind persons, the compensation to come from the appropriation for the relief of the poor.

To Regulate the Sale of Milk.—Senator Gallinger has introduced a bill to regulate the sale of milk and cream in the District. It provides that no person shall sell or procure for sale milk or cream without a permit from the Health Officer: the granting of such permit to be dependent upon compliance with the sanitary regulations prescribed by the District Health Officer.

School Inspection.—The committees selected by the Washington Homœopathic Medical Society and the Medical Society of the District of Columbia have endorsed and commended the action of the District Commissioners in recommending the appropriation by Congress of \$55,000 for the medical inspection of the local public schools. It is intended to appoint eleven medical inspectors at a salary of \$500 each per annum. The positions are to be filled from the ranks of the most competent physicians of the District.

To Prevent the Sale of Unwholesome Food.—The Health Officer has recommended the following regulations governing the sale of meats, and the same has been approved by the Commissioners. No person shall sell or offer for sale in the District any sheep or lamb slaughtered for food until the pelt, head and feet thereof shall have been removed. The violator of such provision shall suffer a fine of not less than \$5 nor more than \$25 for each and every offense.

Macpherson Crichton, M.D.

The Homœopathic Medical Society of the County of Philadelphia.—A regular meeting of the Homœopathic Medical Society of the County of Philadelphia was held at the Hahnemann Medical College January 9th, at 9 P.M. After the regular business meeting, Dr. G. Maxwell Christine gave a demonstration of the X-rays.

The doctor premised his remarks by the statement that he had been requested to give a practical demonstration of the X-ray, which he willingly consented to do, because, although all physicians knew of the subject in a general way, many have not given the matter very deep study nor anything like careful consideration. The result is that while, in a superficial way, the X-ray is a matter of world-wide knowledge, the principles underlying it, while practically very simple, are unknown to them.

The study and practice of the subject has been limited to the few, obviously due to the general lack of teaching in the medical schools, as well as to the fact that the cost of the apparatus has proved an obstacle to its general use.

Dr. Christine stated that he would endeavor to treat the subject as though speaking to the one present who was most ignorant of the matter. He had brought his outfit, and would give every one in the audience ample opportunity for using the fluoroscope, and as the Surgical Department of Hahnemann Hospital had kindly sent over several patients for demonstration, an instructive evening was made possible.

Prof. William C. Roentgen, of Wurzburg, announced to the Wurzburg Physico-Medical Society, on December 8, 1895, that on November the 8th previous he had discovered a new ray, which, for the want of a better name, he called the X-ray. The X represented the unknown feature of the ray. That the new form of molecular disturbance, named by him the X-ray, had certain characteristics, Roentgen had assured himself; but as to the exact underlying principle he was in the dark—hence the term. Little has become known since that date to justify the substitution of any other term for the X-ray, though frequently it is called the Roentgen ray, in honor of its discoverer.

The development of the X-ray is interesting as a matter of evolution of fact from fact. It can be traced from experiments made in light and electricity by various observers. Thus we can begin with Maxwell's theories respecting light, which maintained that waves of light were identical with electro-magnetic disturbance in ether.

Faraday, experimenting along these lines, held that there was a fourth state of matter beyond the three known states of matter—liquid, solid and gaseous—and that this fourth state of matter, like the other three, had to do with molecules. Faraday believed that his fourth state of matter was a state as far beyond the gaseous as was the gaseous beyond the liquid.

Geissler, by means of tubes exhausted of air which was replaced by gases of various kinds, produced beautiful phosphorescent or fluorescent effects, radiating from the cathode. We all remember these experiments having been made by the lecturer on physics. The Geissler tubes then appeared to be merely playthings, and it was little dreamed of, twenty-five or thirty years ago, that these tubes of Geissler would eventually lead to so important a discovery as the X-ray. Nevertheless they did do so. The cathode or negative pole in vacuum tubes which were charged with an electric current of a certain form was destined to occupy a prominent part in the development of a most important discovery. The new-found rays of Geissler were ascertained to move in straight lines, and became immediately the cause of much investigation.

Among the experimenters was Crookes, who modified the Geissler tube by creating in the tube a vacuum and leaving it so without filling it with gases.

Crookes, in 1879, while experimenting with tubes which were exhausted to one-millionth of an atmosphere, discovered the fourth state of matter, first suggested by Faraday. Cathode rays falling on the anode and reflected through the tube to the inner surface produced a fierce bombardment, which Crookes demonstrated to be a new force.

In 1891 Hertz proved that in a Crookes's tube the electric rays proceeding from the cathode or concave pole were capable of passing through an opaque object within the tube. This was another advance, and the Geissler tube, with its simple and yet beautiful phosphorescence, was relegated to the shade.

Interest was now attracted to the fact that objects opaque to ordinary light were not so to rays proceeding from the cathode rays in a charged Crookes's vacuum tube.

As another step in the evolution of the X-ray, Leonard, who had been experimenting with ultra-violet rays in connection with the Crookes's tube, proved that the rays from the cathode passed through opaque objects not only

within the tube, but also outside of it. Hertz had demonstrated this fact with respect to opaque objects within the tube; Leonard now amplified the discovery by extending its sphere of action to objects on the outside of the tube. Leonard also found that the rays penetrated cardboard which was opaque to ultra-violet light, sunlight and arc light.

In 1893 Leonard succeeded in photographing opaque objects by interposing them between the charged tube and a photographic plate.

In November, 1895, Roentgen, while experimenting with the Leonard-Hertz rays, discovered that paper coated with barium-platino-cyanid became fluorescent by rays which passed through a tube covered with black cardboard, the chemical paper being brought within two metres of the tube, the experiment being conducted in a dark room.

Roentgen also discovered that the rays which passed through the cardboard also acted on a photographic plate. This was the gist of Roentgen's discovery, and it was a simple matter to place the hand as an opaque object on a photographic plate, and have the rays pass through the tissues, thus outlining the bones on the plate.

Roentgen believed his X-ray to be due to longitudinal ether vibrations, light being due to transverse vibrations.

Dr. Christine then explained the difference in behavior as to refraction, reflection, polarization, magnetization, etc., between rays of ordinary light, electric light rays, the Leonard-Hertz rays, and the X or Roentgen rays. The difference between these rays in their action on opaque bodies was also shown. The Roentgen ray, while discovered during an inquiry into the action of an ultra-violet ray, was proven not to be identical with that form of molecular action. The Roentgen ray has the following main features:

1. It is not affected by the magnet.
2. It is not readily absorbed.
3. It is not an ultra-violet ray.
4. It is not produced at the cathode, but where the cathode rays fall or impinge on the walls of the Crookes's tube.
5. It is not polarized, refracted, nor much reflected.

In comparison, it is to be remembered that electric light rays are reflected, refracted and polarized.

Roentgen rays are now believed to be produced in the space around the tube, and not within it, and are directly the result of vibrations in space around vacuum tubes through which an electric discharge, more fully to be described later, is passed, and are generated by the cathode electric rays. In other words, the electric discharge is practically electric rays until it hits or bombards the inner surface of the Crookes's tube, and the force is then generated into the new-found rays known as the X-rays.

Williams describes the difference between X-rays, Becquerel rays and light rays as follows:

1. X-rays are a succession of *regular* independent impulses.
2. Becquerel rays are *irregular*, but to a less degree than are the X-rays.
3. All light rays are a succession of *orderly* disturbances in the ether.

It is believed that X-rays are effects of molecular action, just as are those of light and electricity—only of different wave-lengths.

It is also possible that X-rays are really a part of the spectrum.

The two facts with respect to the discovery of Roentgen which stand out prominently and are of the greatest importance are, that paper coated with barium-platino-cyanid becomes fluorescent by rays which pass through the tube, and, secondly, that the rays which pass through the tube would pass through an opaque object and be photographed on a photographic plate.

From the first of these discoveries has been developed the fluoroscope, which is essentially a box, one end of which fits over the eyes, and the other end is made up of a card or screen covered with crystals of barium-platino-cyanid. When this box or fluoroscope is held up to the eyes and the cardboard is held before an active Roentgen tube, the cardboard becomes fluorescent.

Now, if bodies through which the X-ray will not pass, or will pass with more difficulty than through the screen, are held up between the screen and the tube, they appear darker than the screen; thus, if the hand is held before the screen, the screen around about the hand is decidedly fluorescent, the soft tissues of the hand are not quite so, and the bones of the hand, which are denser than the tissues of the hand and screen, show as dark objects. Roentgen placed over his photographic plate a screen of this character and photographed the hand. In using the fluoroscope we simply hold the fluoroscope up to the eyes with the screen directly toward the tube, and interpose between the tube and screen the object—for instance, the hand—at which we are looking.

A few facts with respect to this fluorescent screen are interesting: it will light up behind a book of about a thousand pages, and will show the shadow of a big object, like a knife or a pair of scissors, placed between its pages.

It will show through printers' ink, two packs of playing cards, one thickness of tin-foil, thin blocks of wood, a board of pine 2 or 3 cm. thick, aluminum 15 mm. thick, glass plates not too thick, lead glass, several cm. thickness of ebonite, through the hand and various parts of the body, and even through the bones of the body.

Certain substances, when put in proper form on the screen, become fluorescent when exposed to an active Roentgen tube, such as barium-platino-cyanid, calcium sulphate, uranium glass, Iceland spar and rock salt.

A photographic plate is sensitive to X-rays.

The ordinary fluoroscope, as we use it, is one of barium-platino-cyanid, it being the most sensitive of all the various substances made fluorescent by the X-ray.

An interesting fact with respect to the bombardment of the inner surface of the tube by the electric rays is that the heat there generated has been estimated to be about 100,000°. Whether this is the correct temperature, it is unquestionably very high.

Another interesting fact is that when these X-rays fall upon the skin, effects are sometimes produced which are known as "X-ray burns."

It is believed that the X-ray, as it proceeds from the tube, has no such action as heat action upon the skin; in other words, that it does not include heat rays in its make-up, but that there is a specific action, not yet thoroughly understood, upon the trophic nerves of the part, causing its destruction.

In the study of these so-called "burns," Tesla endeavored to ascribe them to thermal, electrical, electro-chemical, or mechanical effects. Which of these, or whether any of them, are actual causes, is not known—doubtless the future will develop the reason.

The penetrability of objects relative to the X-ray is believed to be in proportion to their density or specific gravity.

An elaborate attempt has been made to show the relationship between the chemical composition of the part and the capability of X-rays passing through it. Ordinarily we assume that the denser the part the more difficult for the X-ray to pass through it. Taking the hand as an instance, the X-ray will readily pass through the soft tissues—it will not pass through a leaden bullet, and with more or less difficulty will pass through the bones of the parts.

Thus far, we have considered the developments of the X-ray from the

Geissler tubes of our student days, and we have shown that the X-ray will pass through objects opaque to ordinary light, will act upon photographic plates, and will make fluorescent certain screens held between the eye and the tube in action. It is now for us to consider the means by which this X-ray is produced.

Dr. Christine now explained in detail the means for exciting the electrical discharge intended to pass through the Roentgen tube.

He explained the static machine, and showed that, while ordinarily effective, it was huge, unwieldy, uncertain, and frequently ineffective, and is gradually being displaced, not only for X-ray purposes, but also for therapeutic uses, by the induction coil. He also explained the induction coil as consisting of a core of soft iron, around which is wound a few turns of coarse wire which is known as the primary wire. About this, properly insulated, is wound a large quantity of fine wire which is known as the secondary wire. The apparatus thus made up consists of a central coil of iron, a primary coil and a secondary coil. The current passes through the primary coil, and, being interrupted, produces at the make-and-break a static discharge in the secondary wire or coil.

In order to have this secondary discharge of sufficient frequency and intensity, there is placed in the circuit of the primary wire an instrument known as an interrupter. The object of this instrument is to give frequent and sudden interruptions. Corresponding with this series of interruptions there is a discharge of electricity in sparks from the poles of the secondary wire. The ability of these sparks or discharges to pass across a gap gives occasion for indicating the capacity of the coil—say an inch coil, a 2-inch coil, a 12-inch coil, or a 25-inch coil, as the case may be, dependent upon the ability of the electrical discharge to pass around the gap.

Wires are made to connect the two poles of the secondary coils with the cathode, or negative, and the anode, or positive coil, of the Roentgen tube.

The instrument is set in motion, and we have the electrical discharge passing through the tube, radiating from the cathode pole, which is concave, to a target of platinum, which is placed at a certain distance from the cathode, and is connected with the anode.

These concentrated cathode rays on the target are reflected with tremendous force against the inner surface of the tube, the regenerating X-rays. Thus we have the ordinary Ruhmkorff coil and the Geissler tube of our school days, modified to produce this most wonderful discovery of Roentgen.

Dr. Christine now explained the various forms of static machines, induction coils and interrupters. He also explained the difference between the ordinary induction coil, with its condenser and mechanical break, and the later form of outfit which included simply an ordinary Ruhmkorff coil and a Wehnelt electric interrupter, which can be connected with the ordinary incandescent light of either direct or alternating character.

The form of tube which the doctor used in the demonstration was excited by a storage battery, and the interrupter was mechanical. If the Wehnelt interrupter is used, it is necessary to provide tubes with heavy targets, because of the fact that this form of interrupter generates such a high degree of heat at the point where the cathode rays concentrate themselves on the target that the latter, unless specially constructed, soon melts.

In some respects the Wehnelt interrupter is a decided improvement upon the ordinary mechanical interrupter, but there are certain disadvantages which possibly time will finally remove.

Dr. Christine now went into details with respect to the action of electrical currents on the Crookes's tube. It is to be remembered that in this tube the vacuum is high, but is not complete, because there are remaining in the tube

a few molecules of air. If the vacuum were complete, electric discharges would not pass through. It has been found that when these electrical discharges are passed through a Crookes's tube the vacuum increases, which is probably by reason of the fact that the few molecules of air which are in the centre of the tube are forced against the inner surface of the tube.

Some believe that these molecules of air are forced into the interstices of the glass wall of the tube. Early in the history of the X-ray, ordinary vacuum tubes were used. In a few minutes after electrical discharges were passed through the vacuum, the vacuum would get too high for the current to pass through, and an alcohol lamp had to be held under the tube, thus heating the molecules of air clinging to the inner surface, causing them to be sent into the inner part of the tube, and practically lowering its vacuum to a point where the electrical discharge could pass through. This was not only very tedious, but was an element of danger with respect to the durability of the tube.

A tube was finally devised consisting of a secondary tube containing caustic potash, which is very volatile.

When the vacuum in the tube becomes high, a spark flies across a gap provided for the purpose as being the part of least resistance. These electrical discharges are concentrated by a secondary cathode in a bulb containing potash, which is now volatilized, and in the shape of a vapor passes off into the main tube, taking the place of the molecules of air which had been forced against the inner surface of the tube. The vacuum now being reduced, the electrical discharge is able to pass through. No longer needed, the potash is gradually recrystallized in its own bulb, from which it again emerges in the form of vapor when the sparks fly across the gap by reason of a higher vacuum.

The device is so accurately adjusted that the tube is automatic, and can be run for hours, and even days, without any attention. An X-ray manufacturer of this city now turns out tubes of this character which have fully displaced the old form of tube.

Passing from the subject of the tube, of which there are many for various purposes, Dr. Christine took up a detailed consideration of the various forms of interrupters, and especially described the Wehnelt electrolytic interrupter.

This form of interrupter was originally invented by Spottswoolde, in '76-'77. It has been used for other purposes than X-rays, but lately it has been found to be serviceable for this kind of work.

In order to prevent as much as possible the so-called "X-ray burns," an aluminum screen is interposed between the tube and the person. A wire connects the aluminum plate with the house gas pipe. The object of this is to carry the forces which are supposed to originate the burn into the earth, and thus disperse them.

The X-ray, when first announced by Roentgen, concerned physicians mostly with respect to surgical matters. Interest attached itself chiefly to foreign bodies in the hand and other parts of the body, and to the determination of fractures and dislocations. For quite a while its sphere was mainly surgical.

The ability to determine differences in density soon made the medical man acquainted with the fact that the X-ray would determine the presence or the absence of consolidation in the lungs, and of opaque conditions in other parts of the body, such as empyema, etc., so that the diagnostic X-ray has begun to be used by the medical practitioner quite as much as by the surgeon. In tuberculosis of the lung it has become an important diagnostic feature. While some maintain that the present means of diagnosis of tuberculosis of the lung, such as the bacteriological examination of sputum and other evidences, are sufficient, it is always a good thing to have an extra means of diagnosis to fall back upon. The X-ray in skillful hands has proven to be a valuable addition to

our diagnostic means with respect to this disease. In enlargement of the heart, certain diseases of the bones, such as osteomyelitis, sarcoma, etc., empyema of the pleura and gall-bladder, the X-ray has been of considerable service. The differential diagnosis between pneumonia and emphysema of the lungs and bronchitis is considerably aided by the X-ray. The same is true with respect to empyema of the pleura, hydrothorax and pneumothorax. The position of the heart and its relative size are also determined by the X-ray. Thoracic aneurysms can be detected and new growths in the chest and abdomen are discoverable by the X-ray. Abscess and gangrene of the lungs are open to diagnosis by this means. Various pathologic conditions of the alimentary canal, such as dilated stomach, which are usually difficult to diagnose, are frequently readily detected by the X-ray. The kidneys, with respect to their position, size and presence, or absence of calculi, are also susceptible of investigation by the Roentgen ray. Foreign bodies in the eye, and even within the skull, are readily detected, and, by means of specially constructed indicators, their exact position is readily determined.

The therapeutic value of the X-ray in treating lupus and other diseases was dwelt upon by the lecturer.

Dr. Christine exhibited some of the apparatus used in detecting foreign bodies in the body. He also exhibited the means by which radiographs are made, showing and describing the photographic plate, the means by which a radiograph is taken, and the process adopted for the finishing of the radiographic picture.

The apparatus brought by the doctor was now set up and put into action. It consisted of a large storage battery, a 12-inch coil with a condenser and mechanical break, an X-ray tube, and a fluoroscope. Several patients from the dispensary were now carefully examined as to pathologic conditions present—the audience filing up one by one and using the fluoroscope themselves. Some of them had never seen a fluoroscopic image of any object, while others were quite conversant with it. Even the latter found pleasure, as one always must, in noting the smoothness with which the outfit worked. Several radiographs and radiographic negatives were exhibited. The meeting adjourned at 11 P.M.

H. P. Leopold, M.D.,

Secretary.

The Saturday Night Club of Microscopists.—The regular meeting of the Club was held at Hahnemann College at 8.45 P.M., October 19, 1901. Three propositions for membership were favorably reported by the Censors, and elected by the Club.

The entertainment of the evening was furnished by Dr. A. Korndorfer, Jr. A demonstration, by microscopic sections and the electric projective lantern, of "Malignant Chorion Epithelioma." The discussion following was exhaustive, and showed the intense interest taken in the subject by those present. Dr. Korndorfer was unanimously and enthusiastically thanked by those present for his fine demonstration.

Several visitors were present. Adjourned at 11 P.M.

Nathan Smilie, M.D.,

Secretary.

The Saturday Night Club of Microscopists.—The regular November meeting convened at 8.45 P.M., Nov. 22, 1901.

Dr. Charles Mohr was elected a member of the Club.

Dr. H. L. Northrop was to furnish the entertainment, but owing to illness he only exhibited a very interesting case of unusually large and anteriorly placed appendix vermiformis in a cadaver.

An interesting and instructive discussion of the causes of tetanus following vaccination was then taken up, and many interesting cases were cited. It was generally agreed that the tetanus germs came from other sources than the virus.

Adjourned at 10.45 p.m.

Nathan Smilie, M.D.,

Secretary.

The Maryland State Homœopathic Medical Society.—The above Society held its semi-annual meeting October 16, 1901.

The program was short, as having one paper by John Hood, M.D., of Baltimore, on "Non-sanitation *versus* Sanitation."

One by Dr. E. Z. Cole, of Baltimore. Subject, "Must the Surgeon Necessarily be an Expert Pathologist?"

One on Ophthalmology, by Dr. William Dulany Thomas, of Baltimore—"Shall Hypertrophied Tonsils be Removed?"

The evening was devoted to an address by Prof. Wm. H. Bigler, M.D., of Philadelphia, Pa., whose subject was "The Law of the Conservation of Energy in Medical Practice." Dr. Bigler stated in his introduction that "we all had our 'fads'"; to some extent this was one of his. Those who attended this meeting expressed themselves very much pleased at having the pleasure of hearing the doctor discuss "energy" from this standpoint.

The Forty-fifth Annual Meeting of the Kings County Society was held in Brooklyn on the 14th of January, 1902, and the following officers elected for the ensuing year: *President*, W. S. Rink; *Vice-President*, W. J. Shrewsbury; *Secretary*, R. I. Lloyd; *Treasurer*, H. C. Allen; *Censors*, H. J. Pierron, W. B. Winchell, H. D. Schenck, O. S. Ritch and W. H. Aten.

The retiring President, Dr. Aten, recommended that a committee be appointed to take steps toward acquiring a permanent home. Upon motion the committee was appointed.

A committee was appointed at last meeting to secure rooms in a more central location. Dr. Schenck reported in favor of Heed's Hall, corner of Bedford and Nostrand Avenue, and this recommendation was accepted.

The Executive Committee is also considering the advisability of serving a light lunch after each meeting.

The Committee of Public Health reported in favor of including whooping-cough among the diseases to be reported to the Health Board, and also that Sunday schools and private schools receive reports from the Board of Health giving names of persons afflicted by contagious diseases. They also recommended that local surface and elevated roads heat their cars properly. Resolutions to this effect will be sent to the proper authorities.

Since our last meeting three of our members have died: Drs. A. E. Underhill and G. H. Doty, of typhoid fever, and Dr. Alanson T. Smith, making a total of eleven deaths during the year.

Just before retiring from office, Commissioner Goetting appointed the staff for the Cumberland Street Hospital, which will probably be opened in a few months:

Consultants—Drs. W. S. Searle, J. Lester Keep, Edwin Chapin, and H. J. Pierron.

Surgeons—Drs. W. W. Blackman, Geo. Clinton Jeffery, O. S. Ritch, and — Smith.

Gynecology—Drs. Clark, Burnham and Bonnell.

Genito-Urinary—Dr. Nathaniel Robinson.

Orthopaedics—Dr. W. H. Pierson.

General Medical—Drs. Daniel Simmons, W. B. Winchell, Amos Ritch, W. S. Rink, M. T. Hopper and C. L. Johnston.

Eye and Ear—Drs. J. L. Moffat, H. D. Schenck, and Alton G. Warner.

Obstetrics—Drs. T. A. Buys and W. C. Latimer.

Podiatrics—Drs. H. B. Minton and W. S. Risley.

Dermatology—Drs. W. S. Love and Herman Street.

Pathologists—Drs. H. C. Allen and E. R. Fiske.

A Definite Income Guaranteed for Life.

Perhaps one of the most remarkable adaptations of life insurance to the needs of a majority of insurers is found in the installment-annuity policy of the Provident Life and Trust Company of Philadelphia. This policy provides for the payment, after the death of the insured, of a definite income for a sufficient number of years (twenty years) to cover the dependent period of the family; and, if the widow should survive this period, guards against the contingency of her becoming dependent upon her children, by continuing the income to her as long as she lives.

Observation has shown that, in the case of the greater number of persons who die insured, the proceeds of the policy constitutes the larger part, if not the whole estate. The previous rate of living, although moderate, would exceed the interest income of the amount of the policy, if securely invested. In many cases, even with great economy, there would consequently be no alternative but to encroach upon the principal, and after not many years the entire amount would be expended. Much good advice doubtless might be given as to the advisability of holding the principal sum intact. But necessity cannot listen to good advice. Few women, however intelligent, have had business experience, or are qualified to make investments. The widow would invest at the beginning most of the money, and she would be fortunate, with her inexperience and dependence upon advice which, however well intentioned, might often be injudicious, if she secured a perfectly reliable investment. As the sum invested would have to be reduced at frequent intervals, probably necessitating the repeated reinvestment of the money, the danger of mistake would be multiplied, and it would be difficult to get a satisfactory investment.

The Provident Life and Trust Company, under its installment-annuity policy, invests the amount of the insurance and accumulates interest upon the investment. Two points are thus secured—the safety of the money and a more profitable investment than would be possible to an individual investor. From the money thus safely and profitably invested, the company pays a fixed annual sum for twenty years, which under any circumstances would carry the family beyond the dependent state. These payments cease at the end of twenty years, but as there is a possibility that the widow of the insured might survive this period and be without support or become dependent upon her children, provision is made in the policy that an annuity of the same amount as the annual installment paid during the twenty years shall be paid to her as long as she lives.

This plan commends itself not only to the class of insurers described above, but should be attractive to persons in every condition of life, both in protecting the family against the pecuniary loss which would be caused by the death of the husband and father, and in providing a certain income for the family during the period of the youth and dependence of the children, and an income for the widow during her whole life. If there were an estate besides the proceeds of the policy, and serious loss in the investment of those funds should occur, the income derived from the company would be sure, and there never could arise the contingency of the widow being left without support.

Nothing need be said of the standing and advantages of the Provident Life and Trust Company. Excelled by no other life insurance comp in this

country, its organization and the peculiar safeguards which surround it as a trust company qualify it in an eminent degree to carry out the provisions of the installment annuity policy.

Benefit of Being Insured.

No better proof of the general recognition of the duty of protecting dependents by life insurance can be found than in the fact that the death losses paid by the regular companies in the United States in the last ten years exceeded \$800,000,000. These figures would sound like a gross exaggeration if it were not known that they are derived from carefully prepared statistics.

Life insurance is needed by all classes; by men of small, of moderate and of large incomes. It is needed by many to save their families from poverty or dependence; and by others as a protection against the deprivation of comforts, conveniences and refinements of living, which by use have become necessities. The successful business man is able in this way to leave as large an estate as if he had lived many years longer to exercise his talents and improve his business opportunities.

The primary purpose of life insurance is to provide indemnity, and in the various modifications of forms which are attempted this end should never be overlooked or subordinated. Among the several forms presented there is none so obviously proper as endowment insurance. Ordinarily the head of a family is confronted with two contingencies. First, there is the danger that his death may be untimely, and that he may leave his family destitute or with an inadequate provision. Secondly, if he should escape this calamity, and should live to the commencement of old age, he might find himself with failing powers without a competence for himself and wife. An endowment policy provides against both contingencies. If death should occur, the amount of the policy is paid to the family; or if the insured should live to the maturity of the policy, the amount is paid to himself as a support for his and his wife's old age.

At the earlier ages especially the difference in premium between an ordinary life policy and an endowment is very slight. The time for such a policy to mature should in most cases not be earlier than 60 or 65. In a company whose risks are well selected, whose investments are made with skill and care, and whose affairs are economically administered, the financial results of endowment policies are very attractive.

An endowment policy is a sure incentive to save money. One reason is the recurrence of the premiums at regular periods, and another and perhaps stronger reason is that small amounts are readily invested in this way, while, as is well known to investors, it is difficult to invest small amounts by ordinary methods. Extended observation justifies the assertion that, in most cases, the matured endowment received at the beginning of old age represents money which would not otherwise have been saved. Further, it must be remembered that money invested in an endowment policy is lifted above the hazards of business.

A New Swindling Method.—The attention of physicians should be called to a couple of men who represent themselves as Cubans, and who are going the rounds of the profession in this city. They offer cigars, which they say are made in Cuba and worth at least 25 cents each. The price asked varies from \$10 per hundred to \$3 per hundred. The cigar which is offered for trial is really excellent. The rest of the box will be found to have a bouquet like a formaldehyde generator in active operation. Several physicians have already parted company with their hard-earned dollars for these celebra "La Fumigatore" brands.

"**Memoria in Æterna.**"—As time flies by, amid the rush and bustle of this eminently practical, work-a-day world, one unconsciously displaces from the mind of to-day the remembrances of the happenings of yesterday; there are, however, some things which should remain "in everlasting remembrance." The gentleness, strength and beauty of the personal character of William McKinley and the inestimable value of his services to the nation and the world at large should not be consigned to the mental dust-heap of oblivion, but should be cherished as a precious heritage by every patriotic American, whether native or foreign born. Feeling confident that their friends in the medical profession will appreciate at its proper worth a souvenir which shall serve as a constant reminder of the life, character and services of our third martyr President, the Arlington Chemical Company has prepared for gratuitous distribution a magnificent enlarged reproduction (17 x 13) of one of the finest and most faithful portraits in existence. Competent critics who have seen this reproduction have expressed themselves as surprised at the faithfulness with which the beautiful Rembrandt effect has been carried out, with its rich, dark sepia tints, and with the general artistic worthiness of the portrait as a whole. The advertisement of Liquid Peptonoids is so unobtrusive as to be entirely unobjectionable. The Arlington Chemical Company, Yonkers, N. Y., will be pleased to send a copy to any physician who may have failed to receive one, together with suggestions for proper method of framing.

The Treatment of Nasal Catarrh.—Mannon (*Cincinnati Lancet-Clinic*) finds no danger whatever from the use of the nasal douche, provided ordinary care is taken and a proper solution is employed. The charge that post-nasal douching is prone to excite inflammation of the middle ear he does not find sustained. All leading specialists employ this method of treatment in the posterior as well as the anterior nares with equally good results. The doctor has had chronic nasal catarrh of many months duration yield to douching when heroically employed. Listerine to which a small quantity of bicarbonate of soda has been added is his main stand by. If hæmorrhage is a controlling feature, he uses instead a saturated solution of tannic acid, to each ounce of which 10 grains of carbolic acid has been added. When the tendency to bleed ceases he returns to the listerine solution. Treated in this way, the most pronounced cases yield in three or four weeks, and are not prolonged by complications or sequelæ.

Grippal Cough—Laryngitis—Bronchitis.—In these affections anti-kamnia is indicated, for two reasons: First, because of its absolute power over pain, at once removing this element of distress and placing the whole system in the best possible condition for a speedy recovery. And, second, because of its power to control inflammatory processes, lowering the fever by its peculiar action on the nervous system. Codeine is strongly indicated because of its power as a nervous quietant, often quickly and completely controlling the cough. In nervous coughs, irritation of the throat, laryngitis, bronchitis and phthisis, where the cough is altogether out of proportion to the amount of expectation, Antikamnia-Codeine tablets will give prompt satisfaction. In fact, in cases of nervous coughs, irritable throat, so commonly attendant upon influenza and la grippe, as well as in subacute laryngitis and slight bronchitis, this tablet alone will often so control the cough that the disease rapidly subsides. This is not strange when we remember that nothing could keep up this irritation more than constant coughing. In the more severe cases of bronchitis and in phthisis, the patient is not only made more comfortable, but the disease itself is brought more directly under control by checking the excessive coughing, relieving the pain, and bringing the temperature down to the normal standard.

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THE STATUS OF HOMŒOPATHY.

BY ALFRED WANSTALL, M.D., BALTIMORE, MD.

(Read before the Baltimore Homœopathic Medical and Surgical Club, December 11, 1901.)

Mr. President and Members of the Baltimore Homœopathic Medical and Surgical Club, and your Guests :

My first impulse, on receiving an invitation to deliver an address before you on this occasion, was to select some subject of general interest that would have occupied the evening and not have taxed your attention too closely. But on second thought, after having understood that the invitation was rather personal than general, and because your membership is composed of young men, I decided to devote the opportunity you so kindly placed at my disposal to the consideration of a subject that has occupied a good deal of my attention, off and on, for a long time. I was further impelled to this course by the fact that I had already committed to paper my ideas upon it, being inspired to do so from having listened to and participated in a discussion, in common with most of you, of a paper read at the last (May) meeting of the Maryland State Homœopathic Medical Society, entitled "The Shibboleth of Homœopathy."

The title of this paper is perhaps somewhat misleading, as it leaves entirely untouched, as of secondary importance, many avenues of thought properly coming under it, such as the present condition of the materia medica, the possibility and feasibility of the re-proving of drugs, and the probable utility of

such a procedure, and devotes itself almost entirely to the primary idea of just what homœopathy is, and why it is what it is.

A clear, practical, unidealized comprehension of the so-called homœopathic principle, or homœopathic relation of the symptoms of drugs to disease, should do more to free the mind from vexation regarding apparent inconsistency, confusion and incompleteness in the materia medica, and to reduce to a minimum the extremes, optimism and pessimism, now so apparent in our ranks, than endless and fruitless efforts to free a subject from difficulties which are organic, and inherent in the very idea itself.

Lest the views herein expressed be considered unduly radical, I quote from Dr. Conrad Wesselhœft's preface of Hahnemann's *Organon* of more than twenty-five years ago: "As for the rule *similia similibus curantur*, physicians agree that it is the most practical guide to aid us in the selection of most, perhaps of all, medicines. We accept it as an empirical fact, not as a theory or hypothesis, as our opponents quite erroneously term it. The explanations of its workings are as numerous and varied as they are unsatisfactory, from Hahnemann to the latest expounder. Yet the rule is a good and safe one; and, though imperfectly explained, we may continue to apply it in practice, till at some future time we may enjoy the privilege not only of contemplating what we have cured, but also how it was done."

What I have to say in regard to homœopathy will, perhaps, be no more radical than has been already foreshadowed by the foregoing quotation. Nor can I hope to be any more satisfactory than previous expounders of the homœopathic law, or rule of practice, whichever it is; as I fully realize how futile is the effort to harmonize such wide differences of opinion as exist as to what homœopathy is, especially as the differences of opinion result in contention rather for an intangible than for a concrete something. It is said that Buckle has pointed out that "women care nothing for the truth, though they will gladly die for what they call the truth." It may well be added that this condition of mind is very common among men practicing medicine, especially homœopathic medicine, to-day. But so long as "the truth is mighty and must prevail," it is a subject that has to be threshed out sooner or later, and no other excuse need be offered for selecting it as a subject for discussion now.

The present is an age of revision—an age of the revision of creeds and dogmas. From time to time it becomes necessary for older theories to readjust themselves to the increased and more positive knowledge of the day. The growth of knowledge is surprisingly slow, and no branch of it is slower, especially when it is considered that it is associated with a department of science, than that of drug therapeutics, or the curative relation of drugs to disease. In this connection the famous aphorism of Hippocrates that “Life is short, and the art long; the occasion fleeting; experience fallacious, and judgment difficult,” has always struck me as being extremely forcible.

The creed, or shibboleth, of homœopathy is comprehended in the two forms of the following formula:

1. *Similia similibus curantur*; the verb *curantur* being in the indicative mood, which is the mood of direct assertion, and signifies “likes are cured by likes,” or “similars are cured by similars.”

2. *Similia similibus curentur*; the verb *curentur* being in the subjunctive mood, the mood of dependency, expressing that the action of existence is possible or contingent, and signifies “let likes be treated by likes,” or “similars may be cured by similars.”*

Which of these two forms Hahnemann actually used and favored is a matter of controversy. The weight of evidence seems to be that he used the second—*similia similibus curentur*. On the other hand, it is contended that he used the first—*similia similibus curantur*, not from actual demonstration from his writings, but from what he is supposed to have had in his mind, and what he must have intended to express.

As a matter of fact, Hahnemann actually speaks of “that homœopathic law of nature” (*Organon*, No. 26), and, “this natural law of cure” (*Ibid.*, No. 28). The word “law” is defined to be “The uniform occurrence of natural phenomena in the same way or order, under the same conditions. Called natural law, or law of nature.” And, “A rule established by custom. A recognized rule of action.”

That is, a law made by God and a law made by man; the one fixed and immutable, the other modifiable according to circum-

* Rendered by E. G. H. Miessler, Columbus, Neb.

stances. There can be no doubt that Hahnemann meant, by the phrases "that homœopathic law of nature," and "this natural law of cure," the uniform occurrence of natural phenomena in the same way or order, under the same conditions—called natural law, or law of nature. And this state of mind, whichever one he may have used, would have been best expressed by the more positive form of the symbol, *similia similibus curantur*—"likes are cured by likes."

Between a natural law of cure, *i.e.*, the uniform occurrence of natural phenomena in the same way or order, under the same conditions, possibly best expressed by the formula *similia similibus curantur* (likes are cured by likes), and a rule established by custom, which is possibly sufficiently expressed by the formula *similia similibus curentur* (let likes be treated by likes), there is an absolute and fundamental difference. The first would seem to imply that there is a natural relation between the means (drug) employed to influence a condition (disease) and the forces (exciting, contributing and predisposing causes of disease) operating to produce that condition; further, that its bounds of applicability are definitely fixed, and that its results are uniform when it is applied within its bounds; while the latter simply foreshadows the general fact that a similarity in the effects of drugs to the effects of disease implies that both have a common place (not necessarily kind) of origin, and, in so far as drugs can influence disease, they are the ones most likely to influence it, without specifying how; and of many similars it remains for experience to determine the most useful, and the degree of their usefulness, without necessarily specifying their ability to cure.

The words "likes" and "similars," as used in the preceding formulæ, have the same meaning, and are defined as follows: "Analogous; agreeing in some notable respect; having resemblance; having or exhibiting no marked or essential difference." In short, they mean a resemblance in unlike things, as is apparent from Hahnemann's own definition of the homœopathic law: "In the living organism, a weaker dynamic affection is permanently extinguished by a stronger one, if the latter (deviating in kind) is very similar in its manifestation to the former." (*Organon*, No. 26.)

The words "similars" and "likes" are descriptive of con-

ditions, not things. Between things differing in kind, the symptoms of drugs on the one hand and the symptoms of diseases on the other, a theoretical relationship of resemblance or similarity may exist; this resemblance may be very strong (but it cannot be absolute), or it may gradually dwindle and become so feeble that it is hardly, or no longer, apparent, when the relatively negative relationship existing between them (or perhaps absence of relationship) will be manifest, and come to be described by the word "dissimilar" or "dissimilarity"; and dissimilarity is negatively comparative, inasmuch as it can increase until a more positive comparative state begins to prevail, which is the apparent antithesis of similarity, namely—contrariety (used in the medical sense of being antagonistic); and contrariety, like similarity, may be so feeble as to be just apparent, or so strong as to seem to be absolute.

The following quotations from a recent (homœopathic) writer serve to illustrate the confusion of ideas existing in regard to the relations of similars to contraries, and their relation, in turn, to laws of cure or rules of practice; the tendency of the mind to be led astray by euphony; and their analysis throws a light on the subject not otherwise obtainable, because they contain a basic truth, though, I think, erroneously applied or not carried to its logical conclusion.

He says: "There are too many evidences of two great therapeutic principles, the principle of similars and the principle of dissimilars, and there are too many evidences of many and varied degrees of similarity and dissimilarity between two conditions and things, to make successful an effort to establish one of these relationships to the exclusion of the other."

"The great relationship of similars exists only because of the great variation of *resemblances* between things and conditions, just as the great principle of dissimilars exists only because of the great variation of *differences* between things and conditions."

"If there is a law of similars, then there is a law of dissimilars; for the essential of a comparison of similar things is that there be a difference which makes individuals of each, and the essential of a comparison of dissimilar things is that there be some resemblance which puts them within the possibility of a comparison. The degrees of similarity are just as varied as

are the degrees of dissimilarity; no more, no less. Similarity exists because of dissimilarity, and dissimilarity exists because of similarity; both are the eternal verities."

Let me analyze them briefly. It is true that "similarity exists because of dissimilarity, and dissimilarity because of similarity." And as "the essential of a comparison of similar things is that there be a difference which makes individuals of each," what is the difference in the present case? The difference is that the symptoms are produced by drugs on the one hand and by diseases on the other. And as "the essential of a comparison of dissimilar things is that there be some resemblance which puts them within the possibility of a comparison," what is the resemblance in the present case? The resemblance is that the symptoms emanate in both instances from a common source, the animal body.

Now, the similarity upon which homœopathy is based is not the resemblance existing in the fact that the symptoms have a common place of origin, any more than the contrariety upon which allopathy is based is the difference existing in the fact that the symptoms are caused by drugs on the one hand and by diseases on the other. The similarity upon which homœopathy is based is the direct resemblance which may exist between the symptoms of drugs and the symptoms of disease; and the contrariety upon which allopathy is based is the apparently direct antagonistic relationship which exists between the symptoms of certain drugs and the symptoms of certain diseases. Symptoms of drugs and symptoms of diseases undoubtedly do exist which are dissimilar in the sense of having neither a homœopathic nor an allopathic relationship (as, indeed, is the case with all symptoms having neither of these relationships in any case immediately under consideration), yet are similar and dissimilar, like all symptoms of drugs and diseases, in virtue of their similar source and dissimilar cause.

Therefore, evidences of a law of similarity do not beget evidences of a law of dissimilarity, but, if anything, evidences of a law of contrariety. At the same time it must be kept in mind that the idea of a contrariety, in the medical sense of being antagonistic,—*contraria contrariis curantur*, in comparison with its apparent antithesis, similarity,—is relatively, if not absolutely, positive, inasmuch as it embodies the concrete idea of

the direct antagonism of a mode of action of a drug to the mode of action of a disease, while the idea of a similarity is relatively, if not absolutely, negative; although it may be construed to embody the idea of opposing a drug disease to a similar natural disease. Whether the idea of a similarity is a true antithesis to the idea of a contrariety is not quite clear to my mind. The subject will be reverted to in another connection.

Hahnemann speaks of dynamic (drug and disease) affections, and of artificial drug diseases and natural diseases; although he did not recognize disease as an entity, but regarded disease (both drug and natural) as only dynamic disturbances of the vital force. He says: "Since many, indeed by far the greater number of diseases, are of dynamic (spirit-like) origin and dynamic nature." (*Organon*, Introduction, page 20.) "Diseases will not cease to be (spiritual) dynamic aberrations of our spirit-like life, manifested by sensations and actions; that is, they will not cease . . . to be immaterial modifications of our sensorial condition (health)." (*Ibid.*, page 23.) It would seem that Hahnemann did not recognize any essential or fundamental difference in the nature of what he calls drug diseases and natural diseases, although he speaks of their differing in kind.

Modern pathology has, practically, been created since Hahnemann's day, and the science of bacteriology has almost revolutionized the previously prevailing conception of the nature of disease. It is questionable whether we are justified, in the present day, in speaking of actual drug disease; certainly we are not justified in speaking of drug disease in the same broad sense that we speak of natural disease. Between the results of a single dose of a drug, from so small as to be almost imperceptible to doses that are lethal, and the more or less typical cycle of acute and chronic infectious diseases and the prolonged duration of the so-called chronic diseases, there is an impassable gulf of difference. A single disease-infection multiplies within the body indefinitely and increases in its effects, and the so-called chronic diseases are, as a rule, degenerations of one kind or another, progressive, retrogressive, or stationary; while the single dose of a drug, regardless of its size, quickly exhausts itself, and even when it kills it does so quickly. Repeated, and even increasing doses of drugs are

necessary, even to maintain the superficial similarity, and even then their effects are rather a repetition of what has gone before in a milder degree, than the progression characteristic of disease.

While Hahnemann regarded both drug disease and natural disease as essentially alike in being dynamic, spirit-like disturbances of the vital force, he did recognize a difference between them in the variation of their acquirement by the human body.

He says :

No. 30. (*Organon*.) "Natural diseases are cured and overcome by proper medicines, because the health of the human body seems to be more readily affected by drugs . . . than by natural morbid agencies."

No. 31. "Those . . . potencies known as noxious influences, inimical to life, do not possess the morbid power of modifying human health unconditionally; but they produce sickness only at a time when our organism happens to be sufficiently disposed and inclined to become affected, and to have its feeling of health altered into morbidly abnormal sensations and functions by the morbid cause that is present. These potencies, therefore, do not make every one sick, nor can they do so at all times."

No. 32. "The case is far different with artificial, morbid potencies which we call medicines. For every true medicine (drug) acts all times, and under *all* circumstances, upon *every* living being, and excites its peculiar symptoms in the organism . . . Thus, every living human organism is always (*unconditionally*) affected, and, as it were, infected, by the drug disease, which, as stated, is not at all the case with natural diseases."

No. 33. "Consequently, experience leads to the undeniable conclusion that the living human organism is far more disposed and inclined to be affected, and to have its feelings altered, by medicinal powers than by other noxious agencies and contagious miasms; or, to express the same in other words, *extraneous, noxious agencies possess a subordinate, and often extremely conditional power; but drug potencies possess an absolute, unconditional power, far superior to the former in its ability to produce ill health (morbid discordancy) of the human body.*"

The distinction which Hahnemann makes between the un-

conditional effects of drugs and the conditional effects of disease refers to the general necessity for the existence, in the human body, of predisposing causes of disease before the active cause can become potent. The whole subject is best appreciated in connection with the subject of infection.

It cannot be denied that drugs, in rare instances, can bring about more lasting (natural) disease indirectly, as when they act, from the violence of their onset or from the constant repetition of their action, in producing a primary lesion that makes an infection possible—acting as a predisposing or contributing cause of disease in the same sense as does exposure, privation, grief, worry, a trauma, and innumerable and obscure constitutional peculiarities known as dyscrasia or diathesis. For instance, an old woman salivated with calomel develops a suppurative inflammation of the middle ear; this, in turn, is followed by mastoid disease, which is operated, and when recovery seems secure she develops an abscess of the liver perforating the diaphragm and lung, and from which she dies. While the whole train of symptoms and the final result may be attributed to the mercurialization primarily, they are not to be regarded as purely (dynamic) effects of the mercury itself; but the mercurialization simply caused the lesion whereby it became possible for the pathogenic micro-organisms already present in the mouth to gain access to the tissues, causing first a local, and later a general (pyogenic) infection.

The fact is recognized that some drugs are capable of causing acute degenerations from their long-continued use in moderate or even minute doses, and perhaps from single large doses, if they are not so large as to cause death too quickly. But diseases, in an actual sense, following the use of drugs, may be caused by infections secondarily, and directly the result of the lesion from the drug. It is well known that salivation can be postponed and limited by a careful hygiene of the mouth, and it may well be asked whether it could not be prevented entirely if it were possible to keep the mouth sterile: and the presence of inflammations and infections following the use of drugs, and attributed to them, has now become a question whether the drug was the true, or only the accidental, contributing or predisposing cause.

Therefore it is important to keep in mind that, between drug

diseases (so-called) and natural diseases, in a causative or actual sense, there is a fundamental difference—a difference that is, perhaps, best expressed by the word “unlike”; and all that they have in common is the similarity, dissimilarity or contrariety of their external, objective and subjective symptoms, just as a similarity, dissimilarity or contrariety may be seen in the symptoms of diseases differing wholly in kind; and it is upon this external, objective and subjective similarity that homœopathy is apparently based.

The question how drugs cure or influence disease, at the place where the drug and the disease actually come in contact, it seems to me, up to the present time, has not received the consideration it deserves in connection with this whole subject. And yet, in the presence of the existence of a natural (homœopathic) law of cure, it is here, and here only, that it should be demonstrable.

Although the question how drugs actually cure or influence disease has not heretofore been involved, the time is at hand when it may be given some consideration, as sufficient data has accumulated to at least permit speculation upon this point. The chemistry of an egg does not reveal in the laboratory all of the chemical elements composing the young bird hatched from it. The eggs of fish are said to have been fecundated without the intervention of the male element, the fecundation having been brought about by a change in the chemistry of its environment. Eggs of the sea-urchin allowed to develop in the sea-water with a slight excess of potassic chloride develop an embryo slightly altered from nature. Or lithic chloride in the water causes a more remarkable change, demonstrating that the male element is only a chemical body, specific though it may be; and there is little reason to assume that chemical bodies and chemical laws cease to operate, and are replaced by imponderable (dynamic) forces, when they can no longer be isolated and followed in the chemical laboratory.

The fundamental differentiation of all tissue is chemical, and the function of each variety of cell, in all probability, is dependent upon its chemistry; and normal and abnormal cell activity, in all probability, are due to stable and unstable chemical conditions. Bacteria grow, outside of the animal body, only when the chemistry of the soil is suitable; and the same

may be assumed to be true when they grow within it. Among bacteria the gonococcus only, under normal conditions, grows on the mucous membrane of the genito-urinary apparatus and the conjunctiva; all of which can be explained by chemical affinities and chemical repulsions. And by analogy it may be assumed, and is probably true, that, in so far as diseases are curable, or are influenced favorably, by drugs or by their analogues, the change is brought about by chemical means, following the laws of chemistry, directly, indirectly or intermediately; and that the so-called specific action of drugs, their selective action, or disposition to act on special organs, tissues or cells, or groups of the same, will ultimately be explained on the basis of their chemical affinities. Selecting specific instances, we may now refer to intermittent fever, diphtheria and syphilis. Each of these diseases is fairly well understood, and each, in a fairly strict sense, has a curative treatment. The power of antitoxin in neutralizing the toxin of diphtheria in the animal body is, probably, resident in the fact that chemical bodies in the antitoxin combine with chemical bodies in the toxin, altering or neutralizing their toxic properties. The fact that the alkaloid of cinchona bark does, and the alkaloid of belladonna does not, cure malaria, is probably due to the fact that the former alkaloid has some chemical affinity for the plasmodium malarie which the latter alkaloid has not. And the same may be assumed for the iodide of potash and mercury in syphilis, although the cause of this disease is unknown.

The staining qualities of the various elements of the blood furnish an exquisite illustration of selective chemical affinities. In neutral mixtures of acid and basic stains the hæmoglobin of the red-blood corpuscles stains only in the acid stain, the nuclei of the leucocytes staining only in the basic stain, the protoplasm of the leucocytes possessing a greater and less affinity for the same stain, and their granules have an affinity for the basic, acid or neutral color, according to the character of the leucocyte. What is true of the cells of the blood is also true of all the cells of the body, to a greater or less extent.

So that, when we come down to the concrete fact of how drugs cure or modify disease or the phenomena of disease (not how drugs are to be selected for this purpose), the existence of

an actual, natural, universal homœopathic law of cure is more than doubtful. There can be no doubt that there is a kind of evidence of the existence of such a law; but if it has an actual existence, in the very nature of the case it must be restricted, and at the utmost it could be only one among other laws, for we must recognize the fact that no cure can result from the use of drugs that is not governed by law.

Therefore, the opinion may well be expressed that the theory of the specific or dynamic action of drugs—vague forces, following vague laws of similitude or contrariety—will give place to the theory of chemical forces following chemical laws, modifying or curing disease by chemically acting upon its exciting causes, its predisposing or propagating causes, its effects and results, or its toxic products, directly, indirectly or intermediately.

This opinion may be more acceptable if it is less abruptly presented. In using, as drugs, the inorganic elements, or their compounds, the idea of their acting as chemical bodies in modifying or curing disease is not hard to accept. As the germination and growth of plants is only a matter of difference in their chemistry, their physical difference is also only a matter of their varied chemical constitution. Admitting these facts into the mind, why should we seek their vital (drug) activities and differences in anything else?—especially when we couple these facts with the fact that protoplasm itself is not a single chemical substance, but a highly complex body.

Inasmuch as a reputed law of cure is the subject under discussion, it is necessary to examine, briefly, what is understood by the word "cure." As has been already mentioned, the word "cure" is derived from the latin verb *curare*, which really means to take care of (from its root noun *curo*, care), or to treat. The common understanding of the word "cure" surely goes farther than this, and is commonly understood to mean "to make well," *i.e.*, the more or less sudden bringing to an end of a disease by some intervention, which disease, without this intervention, tends either to be prolonged indefinitely, or to terminate in death; or the more or less abrupt interruption or abortion of a self-limited disease, *i.e.*, its termination before the completion of its cycle. The instances in which diseases are cured in this sense are, unhappily, rare.

Instances in which drugs alone are used in the treatment and cure of disease are also uncommon. It is the exception when other means are not brought into use to aid in the treatment and cure of disease, as rest in bed, change in occupation, change in diet, change in environment, hydro- and electro-therapeutic measures, moral influences, etc.; and whenever such aids have been called into use, they necessarily reduce the potential value of the drug in the case.

The ideal cure of disease would be, of course, the abrupt ending of it by the removal of its cause. But the cause of disease is both complex and compound, and involves the consideration of both exciting and predisposing causes, and the latter are not always single, and concerning which almost nothing is known fundamentally. For the purpose of illustration, the following cures are referred to: Syphilis, a not self-limited disease, may be said to be cured, after a more or less indefinite time, by the prolonged use of mercury and iodide of potash; malarial fever, a not self-limited disease, is almost abruptly terminated in any period of its course by the use of quinine; diphtheria, a self-limited disease, but not definitely so, is more or less abruptly terminated by the use of antitoxin, and only in proportion to its early administration. While much is known as to the exciting causes of both diphtheria and malaria, nothing whatever is known as to their predisposing causes. In comparison with the ordinary treatment of disease by drugs or their analogues, these instances may be regarded as comparatively ideal types of cure; for they are characterized by the small number of drugs used, they practically cover the whole course of the disease under consideration, and are followed by fairly uniform results.

In striking contrast to this is the ordinary use of drugs in the treatment of disease where they are largely limited to the treatment and amelioration of symptoms and conditions; and owing to the general simplicity of the action of drugs, in contrast with the progressive and changeable character of disease in general, numbers of drugs have to be used, in turn, in the treatment of the same disease, and even in individual stages of the same disease, or more than one factor of the disease has to be met at the same time.

Or the action of drugs is limited to the presumable shorten-

ing of the duration of disease or the prevention and removal of complications and results; or diseases do not require drug treatment; or drug treatment is so supplemented with hygienic and other aids as to disqualify it to be spoken of as curative, or even helpful. There is comparatively little in the domain of drug therapeutics that can be confidently spoken of and demonstrated as actually curative in disease classified nosologically, in any strict sense. The physician is more often engaged in an intelligent effort to pilot the patient with comparative comfort and safety along an involuntary journey, than in saving him the journey at all, or even cutting it short.

In all probability the most successful field for the use of drugs, especially when applied according to homœopathic principle, is in the prevention of classifiable disease, for which it is peculiarly well adapted through its symptomatological application to the premonitory symptoms of disease itself, or to the symptoms of beginning or existing conditions predisposing to disease. Curiously enough, Charles S. Mack's definition of the cure of which homœopathy is the law would seem to be restricted to this class of cases. He says: "The cure of which *similia* is the law is the immediate transformation from abnormal to normal (or approximately normal) of vital processes, and in consequence their effects, *i.e.*, before these effects become knowable pathological entities or can be classified nosologically." It is obvious that all such cures must always exist as a mere matter of personal experience, and without the possibility of demonstration, and are, therefore, comparatively valueless in determining a scientific knowledge of drugs to cure disease.

There is another class of cures reported from time to time in homœopathic literature, almost always of single cases of rare, peculiar, intractable, or apparently incurable or malignant disease. Three cases recently reported by Timothy Field Allen, M.D., in the *Homœopathic Recorder* for January, 1901, will serve to illustrate this class. It is difficult to give such cases their proper place in the domain of drug therapeutics. I have long since come to regard them as curiosities in drug therapeutics rather than practical, everyday contributions to the subject. It is perhaps enough to say that they are probably unique in Dr. Allen's long and active medical career, and

that they cannot be duplicated in homœopathic literature, and that similar instances of apparent cure occurring in the experience of various (homœopathic) physicians would be as variously interpreted. To establish the power of drugs to cure any class of cases, a fairly uniform result in a series of cases is absolutely necessary, as single instances occurring here and there can just as well be due to accidental causes or mistaken diagnosis.

In connection with the cure of disease by drugs there is one consideration that should always be kept in mind, and that is, after trying to give every factor its true value, it is difficult to conceive of a disease that is capable of cure by drugs that is not also capable of natural or spontaneous cure; and this without depreciating the value or power of drugs in the treatment or cure of disease, or assuming that disease capable of natural or spontaneous cure will be cured without their use.

There has always existed in the human mind, professional as well as lay, a profound belief in the efficiency of drugs in the treatment and cure of disease, and this belief has something of the nature of a religious faith. We have all heard the statement made that God created diseases, and that He also created drugs for their relief. Hahnemann himself must have had this idea more or less rooted in his mind, for when he became convinced of the want of efficiency of allopathic methods and allopathic principles he did not turn to the non-use of drugs, but to another principle of application, and different methods of preparation and administration; and all of which he believed to be based upon a God-given law.

The abiding mystery is that drugs ever came to be used in the treatment of diseases, unless as the outcome of the idea expressed above. That substances whose very names indicate their incompatibility with the animal economy in a state of health should come to be regarded as not only harmless when the animal body is afflicted with natural disease, but salutary, is indeed strange. The modern drug nihilist argues that what will make a well person sick will make a sick person sicker. But it may be assumed, within certain limits, that drugs do not always act the same in disease as in health; and, while the smaller doses of homœopathy undoubtedly largely deprive drugs of their health-disturbing properties, they do not justify the assumption of a fundamental difference in their kind of

action, but only a difference in its degree. Yet a careful consideration of all the conditions should excite wonder, not that drugs do so little, but that they do so much.

The fundamental basis of all drug therapeutics is the fact of the power of drugs to excite health-disturbing phenomena in the animal organism, and the further fact that natural disease and the phenomena of natural disease are more or less modified by the health-disturbing properties of drugs. With these facts before the mind and accepted, it is a perfectly natural corollary that those symptoms of drugs which are similar to the symptoms of disease, although they have nothing more in common, fundamentally, than their superficial similarity, should be selected for the treatment of disease, regardless of whether they are to be so applied indirectly, according to the principles of allopathy, on the basis of their apparent antagonism to some other symptoms or conditions,—*contraria contrariis curantur*,—or directly, according to their similarity, homœopathically—*similia similibus curentur*.

Furthermore, this dual application of the symptomatology of drugs in the treatment and cure of disease is indissolubly bound together by the fact of the dual action of drugs, known as their primary and secondary action, or their alternating or opposite effects. So that, when they exist, it is practically impossible to say whether a prescription based upon either is made upon the principle of similars or of contraries, save that certain theoretical considerations decide it on the basis of the size of the dose. It is generally stated that the primary effects of drugs are produced by the smaller or moderate doses, and the secondary opposite or contrary effects by the larger or more material doses of the drug in question, with or without the primary effect having been manifest, and that a prescription is homœopathic to either when the smaller dose is prescribed for symptoms similar to the primary effect and the larger dose for symptoms similar to the secondary effect, and, conversely, either prescription would be allopathic; and although definite laws have been promulgated to make apparently homœopathic either extreme of this dual action of drugs, they have received very little recognition in practice, partly on account of some uncertainty as to what are the primary and what are the secondary effects of certain drugs, and partly on account of the extraor-

dinary variability in the size of the dose in homœopathy, both in making provings and applying them therapeutically. All of which adds to the difficulty of accepting the doctrine of a natural, universal, homœopathic law of cure.

Homœopathy owes its existence to the fact that the instances in which drugs can be applied in the treatment and cure of disease on the basis of their similarity are incomparably more common than those in which they can be applied on an apparent allopathic or antagonistic relationship. As has been already mentioned, the idea of an allopathic or antagonistic relationship between the effects of drugs and diseases is relatively positive and concrete, while the idea of a homœopathic relationship, in comparison with the former idea, is relatively negative and abstract. In the former case the difficulty is in finding drugs with an apparently positive antagonistic relationship to disease, and this fact possibly accounts for the dominant school of medicine having departed from the limits of the dogma—*contraria contrariis curantur*; while, with the latter, the difficulty is not in finding drugs whose symptoms are similar to those of disease, but in differentiating between the few or many showing a similarity in whole or in part, or of one kind or another. And the width of the application of the idea of what constitutes a similarity, owing to its negative character, is practically limitless within the bounds of the symptomatology of drugs, aided and fortified by clinical and other data, and accounts for the fact of the enormous latitude in homœopathic prescribing without apparently departing from its principles.

Hence that feature of drug prescribing peculiar to homœopathy, namely, individualization. There is, undoubtedly, some confusion of mind in the homœopathic school as to just what is the significance or importance of individualization, and what is its relation to the supposed law of cure. Many believe it to be the fundamental essential of homœopathy itself, and they refuse to make use of, or do not recognize, any of its accumulated results, and insist that it is never to be departed from; others almost fail to recognize its existence at all, or that it has existed, and use only its accumulated results without giving a thought to how or why they are accumulated.

Individualization is not so much a fundamental essential of homœopathy as it was and is a necessity of the abstract and

negative idea of treating diseases by drugs according to the similarity of their symptoms, and the great number of drugs frequently showing some kind of a similarity to some individual disease or condition in whole or in part. With the accumulation of knowledge or experience derived from previous individualization it has become less and less a factor, with the advance of time, in everyday work, and its use is being more and more restricted to conditions and circumstances in practice in which there has been no accumulated experience.

It was and is a necessity to distinguish or select a single drug from few or many possessing a similarity to the case immediately under consideration: and it is and was reached by drawing upon every possible source of information, and even from such an impossible one as the imagination itself. The pure pathogenesis is and has been utilized to its extreme limits: and, with this exhausted, gaps that were left had to be filled in from other sources, such as clinical or empirical symptoms and conditions, idiosyncrasies of diseases and patients, and acquired and inherited peculiarities of individuals, which would perhaps come under the head of predisposing causes of disease; all of which came in time to be translated into the language of drugs and incorporated into the *materia medica*, and from whence they come again to be used in the widest possible generalizations in the cure of disease.

Instead of restricting itself to the necessarily narrow and limited theoretical bounds of a natural law of cure, homœopathy is found availing itself of every practical resource of drug therapeutics, regardless of its source, finding in each, thanks to the abstract and negative quality of the idea of a similarity, some elements sufficiently similar to satisfy its elastic conscience, translating them into its own peculiar language, and incorporating them in its archives; so that it has come to be a kind of storehouse of the world's drug therapeutic experience. And there has not been any drug therapeutic experiment that has had any vogue during the time of the existence of homœopathy and before, however completely it may have since disappeared, traces of which cannot be found in homœopathy to-day. This does not constitute one of its demerits, but just the reverse. In spite of the fact that it has been apparently bound down with a narrow dogma, it has met, and

striven to meet, the many varied conditions of disease in an extraordinary manner.

As the cause of disease is both complex and compound, involving the consideration of both exciting and predisposing causes; and as the origin of the symptoms of disease is also both complex and compound, involving the consideration of specific symptoms originating directly from diseased areas, and indirectly from areas directly and indirectly influenced by the first; and general symptoms resulting from the products of disease in the circulation and fluids of the body, as toxins, etc.; and, finally, symptoms peculiar to the patient, due to diathesis or chronic disease; it is as obvious theoretically as it is found practically that the treatment of disease by drugs involves innumerable and complex considerations, varying with every disease and with every case of the same disease, as well as with every stage of it. All of which conditions are better met, perhaps, with what is known as the homœopathic method of selecting drugs than with any other principle of selecting drugs devised by man. However well the homœopathic principle may be adapted to meet the manifold requirements of practice, indeed, the more completely it does this, the less likely is it to be based upon a natural law of cure,—the uniform occurrence of natural phenomena in the same way or order under the same conditions,—but rather is it qualified to bring out practically whatever may exist in drugs having a curative relation to disease, or its exciting or predisposing causes, regardless of how or what this curative relation is to do.

How homœopathy accomplishes its purpose will bear some review, although it involves some repetition in greater detail of what has been already said under the subject of individualization. In the beginning, when experience was still wanting, the establishing of a similarity, or rather the differentiation between few or many drugs producing symptoms apparently similar to the symptoms of the disease in question, was necessarily largely a question of the totality of the symptoms, *i.e.*, the drug possessing the greatest number of the symptoms of the disease in question was selected as the *similimum*; therefore prescribing according to the totality of the symptoms was a necessity of the time. With diseases constantly recurring, and classified nosologically, continued prescribing for their to-

tality in time came to show fairly constantly recurring results in regard to fewer and fewer drugs, with the final result of its leading to the treatment of certain uncomplicated diseases with certain drugs whose pathognomonic symptoms corresponded to the pathognomonic symptoms of the disease. This is a direct result of experience from prescribing for the totality, and necessarily takes its place to a great extent, the use of the totality holding its place in those conditions in which there has been no previous experience, or in conditions occurring so seldom that experience is of very slow growth.

The constant occurrence of certain symptoms of certain drugs in various diseases gave rise, in the course of time, to grand characteristics or keynotes, and the relative value of single marked or characteristic symptoms as against the numerical value of symptoms became an active factor in homœopathic prescribing. The advantage has been largely in favor of the former, mainly owing to its greater simplicity, ease and speed of application, the human mind always following the lines of least resistance, and, finally, because it is in keeping with experience or accumulated personal knowledge. However correct a principle may be theoretically, if it is not handy it is doomed to failure or neglect. Associated with characteristics or keynotes has been the introduction of purely clinical symptoms of disease into the *materia medica*—*i.e.*, striking and frequently occurring symptoms of disease not found in the pathogenesis of drugs, or at least not found in the pathogenesis of the drugs which have frequently occasioned their removal. The introduction of such symptoms into the *materia medica* is the most striking instance of pure empiricism to be found in homœopathy, and is a glowing tribute to the inadequacy of a supposed natural law of cure. But as a practical aid or contribution to drug therapeutics, and as a means of preserving the individual's personal experience, it is probably equal to the pathogeneses themselves.

Another modification or application of the homœopathic rule of prescribing has been comparatively recently advocated by Dr. Woodward, of Chicago, and is known as the sequential relationship of drug symptoms to the sequential relationship of the symptoms of disease. The success of an idea is often assured by a euphonious expression in which to embody it, and

“sequential relationship” certainly sounds well. The thought it embodies is that the drug is to be selected for the treatment of a disease whose symptoms have evolved in the same order as the symptoms of the disease have evolved, or as the present disease itself has evolved from preceding symptoms or diseases, regardless of the lapse of time, even going back through the patient’s entire history. It is, if not the most abstract, at least the most difficult of all the variations of prescribing homœopathically, and, unlike them, does not seem to be the outcome of any of the exigencies of practice. If simplicity in drugs prescribed is an essential of homœopathy, so also should be simplicity in selecting them, so far as it is attainable.

In contrast to the above, as showing how an exigency of practice has been met, and how far an abstract idea may be stretched to meet such an exigency, is the creating, as characteristics of drugs, probably on the basis of some obscure physiological consideration, such purely clinical or empirical symptoms or conditions as nutritional defects or peculiarities of the human body, when we are instructed that they call for the administration of certain (generally chemical) drugs, and almost regardless of all other considerations. The same idea, somewhat differently expressed, is embodied in Schuessler’s treatment of disease with the so-called tissue salts, and accounts for the great vogue which this treatment has had in homœopathy, even to the extent, with many, of a complete system of therapeutics, and for its having left an indelible impression upon it. Part and parcel of the same idea, in a modified sense, is the use of the nosodes, the products and exciting cause of disease; Hahnemann’s theory of psora and psychosis; all of which is comprehended under the idea of diathesis and dyscrasia, and for which a new term has been recently coined in “diathetic homœopathy.” All of which, while perhaps fully justified by analogy, by experience, and by results in practice, certainly can be no part or parcel of a natural homœopathic law of cure, and can be explained and justified on no other ground than that of empiricism.

Homœopathy is essentially a system of drug-giving therapeutics, and Hahnemann, in his “Review of Physic,” dwells with especial force upon the inadequateness and clumsiness of nature’s methods in contrast with the simplicity and certainty

of those of homœopathy. As illustrating how profound was his belief in the power of drugs to cure disease, the following quotation from the *Organon* will suffice: "In order to cure gently, quickly, unfailingly and permanently, select for every case of disease a medicine capable of calling forth by itself an affection similar to that which it is intended to cure." (Intro., p. 43.) It may be surmised that it is this very profound belief in the universal necessity and unfailing efficiency of drugs to cure disease that leads so many practitioners astray and into unhomœopathic methods, and from which they seldom recover.

Once having a profound belief in the power of drugs to cure disease and their absolute necessity engrafted in the mind, it follows naturally that this idea will be associated, consciously or unconsciously, with the idea of force. If the individual happens to be visionary, idealistic and religious, his idea of force will tend to the spiritual, and he will soar upward from potency to potency until he reaches his limit; if he happens to be commonplace, practical, materialistic, his idea of force and infinitesimals will be wholly, consciously or unconsciously, incompatible, and will be embodied in what he can smell, taste and weigh. The difference between them is not one of kind, but of degree. So that it follows naturally that the majority of the practitioners of homœopathy, in their early and inexperienced years, their years of anxiety and solicitude, not knowing what to expect, and anticipating results from their early teaching not ordinarily attainable, and realizing the incompatibility of Hahnemann's idea of the nature of disease and that of modern pathology, on their first disappointments with attenuated drugs inevitably turn to stronger and stronger doses of such drugs as they have been taught to handle; and, their disappointments being no less here, they readily fall into methods harmonizing with their knowledge of disease, which seem to be physiological or rational, which are the vogue, or which appear to be time- or worry-saving. Between these two extremes there is undoubtedly a middle ground, but upon which, one has to confess, the footing is very uncertain.

It is not the purpose of the writer to defend the alternation of remedies or the use of compound tablets, for he believes that neither are in keeping with the homœopathic principle,

and are subversive of sound therapeutics; nevertheless, there are abundant theoretical reasons for both. When Hahnemann sublimated the flowers of sulphur with the inside of the oyster shell in his crucible he sowed the seeds of compound tablets, and it would have been strange indeed if it had not borne fruit. The use of all chemical compounds, as of arsenic, iodine, phosphorus, lime, mercury, etc., is only the initial step to alternation and compound tablets. The fact that they form chemical compounds does not alter the circumstance that the thought is there. And, entirely apart from precedent, or suggestion from the example of others, the profoundly complex character of the origin of the symptoms of disease, in contrast with the comparatively simple action of drugs, consciously or unconsciously would inevitably have led those deeply imbued with the necessity of drugs to their alternation and compounding.

Psychology plays a very important rôle in the art of therapeutics, and every human being is as much an individual in his interpretation of a dogma as we are taught he should be as a patient. And in another sense psychology plays an equally important rôle, consciously or unconsciously, as a therapeutic agent—so important, indeed, that it has come to be used as an all-sufficient therapeutic principle; and no faculty will ever be able to determine what, in the art of therapeutics, is due to psychological influences, and what is due to the more material means the physician may use.

In conclusion: There are physicians practicing homœopathy to whom it is a religion and a faith; who unconsciously cling to the ancient belief in a divine infliction of disease, and the providential providing of drugs for their cure; who believe in the absolute necessity, efficiency and all-sufficiency of drugs in the care and cure of disease; whose faith is embodied in a law of nature, a natural (homœopathic) law of cure; whose shibboleth is *similia similibus curantur*, limitless in its application, or only limited by the individual physician's knowledge of the pathogenetic effects of drugs; who fail to recognize, or deny, that there is anything in the pathogenetic effects of drugs not curative in disease, and that there is anything in disease not curable by drugs; and that whatever cures are wrought by drugs, and under whatever conditions they may have occurred, are to

be ascribed to the conscious or unconscious action of the divine natural (homœopathic) law of cure, positive, concrete, absolute, universal.

There are other physicians practicing homœopathy who believe that the relation of drugs to disease is fortuitous; an accidental relationship which recognizes that there are phenomena of drugs, probably, not curative in disease, and phenomena of disease and diseases not curable by drugs; and that the great general fact of the similarity of the symptoms of drugs to the symptoms of disease constitutes a great working rule, whereby those drugs which act upon the same organs, regions, cells or groups of the same are made manifest, and whose curative relationship remains to be established by experience, directed to a greater or less extent by individualization, leaving the whole subject why drugs cure disease undetermined; that innumerable and inscrutable by-conditions may render futile the most careful prescription; that the idea embodied in the shibboleth *similia similibus curentur* is necessarily negative, abstract, relative (comparative); while it is a means to an end permitting the widest possible generalizations from the narrowest possible specializations, it is not the only means.

There is here an apparent legitimate difference of opinion between two classes of physicians practicing medicine under the same general principle. There can be no doubt that one of these classes is the follower of an exclusive dogma, but surely the other is not. That the belief of the latter in the practical vitality of the general principle of selecting drugs for the cure and treatment of disease according to the similarity of the symptoms of each should exclude it from a legitimate right to participate in the general growth of therapeutics, which by no stretch of the imagination can be brought within what it considers the normal sphere of homœopathy, is to be denied. The ordinary progress of therapeutics may furnish instances in which there is abundant excuse for departing from what has been considered successful homœopathic treatment, for methods that are simpler, and which experience has shown to be fairly successful. The great drawback to homœopathy, and the almost fundamental obstruction to its growth and progress, is the intrinsic difficulty of its careful and intelligent interpretation at the bedside. The minds of all men are not equal, and the

embracing of a dogma by many men is no proof that they can all have a working comprehension of all its intricacies. And that men should not be railed at for not being better homœopathists when their homœopathy is fully equal to their abilities is the natural outgrowth of the accumulated experience of others, or is entirely in keeping with a rational interpretation of the idea upon which it is based.

TINCTURES.

BY T. H. CARMICHAEL, M.D., PHILADELPHIA, PA.

THE appearance of the second edition of the standard homœopathic pharmacopœia under its new and more comprehensive title, "The Homœopathic Pharmacopeia of the United States," should again direct attention to the excellencies or defects of homœopathic pharmacy, and wherein it differs from the pharmaceutical methods of the old school. For this purpose a brief examination of tinctures may be selected.

Of all the alcoholic preparations of pharmacy, tinctures are to be preferred, because they are direct solutions of the medicinal virtues of plants (or other substances) made without the aid of heat, and made by employing a sufficient quantity of menstruum to exhaust the plant or drug, and to keep its active principles in solution.

This fact has always been recognized in homœopathic pharmacy, and Fluid Extracts and Concentrated Liquors have never found a place. It is true that, owing to the lack of an authorized pharmacopœia, homœopathic tinctures were made of various strengths, and it was not until 1897, when the present pharmacopœia was adopted as official by the American Institute of Homœopathy, that the standard strength of the tincture was fixed as one part of the drug (dried) in every ten parts of tincture.

In the United States Pharmacopeia, tinctures vary in strength from 0.4 to 50 per cent.—the majority probably are from 10 to 20 per cent.; so that the average strength of tinctures in the two pharmacopœias probably does not vary greatly.

For a comparison of the strength of tinctures made accord-

ing to the Hom. Phar. of the U. S. with that of tinctures made by the various unofficial guides previously employed in homœopathy, the reader is referred to the admirable article on "Comparative Strength of Tinctures," by J. Wilkinson Clapp, M.D., in the *HAHNEMANNIAN MONTHLY*, Dec., 1898.

A comparison of the real strength of tinctures, however, does not end here, nor can it be conveyed by the letter of the pharmacopœias. It is a well-known fact that one dried-plant tincture or extract may be several times as strong as another tincture or extract of the same plant, both having been made alike. This has given rise to the method of assaying—a more or less complicated procedure for estimating the quantity of alkaloids or glucosides in a given quantity of the drug, and then making the tincture or extract so as to contain them in definite quantities. This method cannot, however, be applied to all tinctures, and thus far includes only opium, cinchona and nux vomica.

In homœopathic pharmacy greater strength of tinctures than is expressed by the official figures $\frac{1}{10}$ is also secured, but in a different manner, viz.: by employing, wherever practicable, green plants gathered at their periods of greatest activity. It is a matter of demonstration that a tincture of bryonia made from the fresh root of $\frac{1}{10}$ strength (that is, containing the equivalent of 1 part of the dried root in every ten parts of tincture) is of greater physiologic or therapeutic strength than a tincture made from the dried root of the same ($\frac{1}{10}$) strength. Before the new pharmacopœia appeared, bryonia tincture was made by expressing the juice from the root and adding an equal part of alcohol; and even this tincture, whose strength was not over six per cent., was preferred by old-school physicians, who had become acquainted with its merits, over the tincture of the dried root, on account of its greater activity, and druggists bought the fresh-plant tinctures in order to fill their prescriptions.

The method adopted to secure a uniform strength from year to year in these fresh-plant tinctures is worthy of reproduction here. It is familiar to some, but by others is understood with difficulty. It was adopted from the British Homœopathic Pharmacopœia, and consists in weighing a given quantity of a fresh plant, and then evaporating it to dryness. It is then

again weighed, and the weight lost represents the moisture of the plant. This plant-moisture is to be taken as so much water, or as part of the menstruum or solvent, and the tincture is made so as to contain the equivalent of one part of the dried drug in every ten parts of tincture. Tables of the standard quantity of solids, plant-moisture and menstruum necessary to make 1000 c.c. of tincture ($\frac{1}{10}$ strength) have been prepared, and are given under each remedy.

For illustration, let us again consider bryonia. It is a tincture of the fresh root, which is to be collected before the plant flowers. In order that it may have a drug strength of $\frac{1}{10}$ (one part dried drug in ten parts of tincture), it is to be made according to the following formula :

Bryonia moist magma containing									
Solids,	.	.	.	.	.	.	.	.	100 gm.
Plant moisture,	.	.	.	.	.	.	.	.	400 c.c.
									500
Strong alcohol,	.	.	.	.	.	.	.	.	94 per cent., 635
									<hr/> 1135

This makes 1000* cubic centimetres of tincture containing 100 gm. of solids, and, therefore, $\frac{1}{10}$ strength.

The excess, 135, represents waste, including 35 parts shrinkage of volume in combining the alcohol and water (plant-moisture).

If, in another year, a given quantity of bryonia root containing 100 gm. of solids should have only 350 c.c. of plant-moisture, then 50 c.c. of distilled water should be added to it to bring it up to the standard (400), or this water may be added to the menstruum.

On the contrary, should bryonia root containing 100 gm. solids have 450 c.c. plant-moisture, the excess (50 c.c.) should be allowed to slowly evaporate. (In some other drugs such excess could be deducted from the water used with the alcohol to make up the menstruum.)

Thus by considering the natural moisture in the fresh plant as so much water, and thus as part of the menstruum, the strength of the fresh-plant tincture is expressed in terms of the dried plant (or of the solids contained in the tincture), and therefore a uniform strength of tincture is secured.

The value of fresh-plant tinctures has never been appreciated by the old school. There are, indeed, under the title "*Herbarum Recentium*," in the U. S. P., directions given for making a certain number of tinctures from fresh plants, but these have been little used.

In the case of *rhus toxicodendron*, it has been generally admitted that, as the active principle was supposed to be volatile in its nature and contained in the leaves, its tincture should necessarily be made from the fresh plant (leaves). If, however, it be true, as asserted by Prof. Sollman in his recent "*Text-Book of Pharmacology*," that "recent investigation has shown that it (the active or toxic principle of the several species of *rhus*) is neither an acid nor volatile, but a fixed oil (*toxicodendrol*)," then some other reason must be given for preferring a fresh-plant tincture of *rhus*.

The writer has used a tincture of *rhus tox.* that was made within twenty minutes after the plant had been collected, and this tincture was so active that great care had to be taken in its use.

Homœopathists have reason to be satisfied with their pharmaceutical preparations, especially their tinctures. The uniform strength $\frac{1}{10}$ is probably as strong as the average tincture can be made, for enough menstruum must be used to exhaust the plant and to hold the active principles in solution. Some hold that a larger quantity of menstruum must be used in order that these essential points may be attained, and for this reason the French Homœopathic Pharmacopœia makes $\frac{1}{20}$ the proper strength for tinctures.

There is one minor disadvantage which many fresh-plant tinctures and the second decimal (2x) dilutions made from them necessarily have, viz. : that they cannot be poured upon globules or disks without disintegrating them. This is due to the water which they contain. In order to make the second decimal (2x) dilution of *bryonia*, one part of tincture (θ), four parts distilled water, and five parts alcohol, are employed.

This will, of course, dissolve cane-sugar globules; and, where the θ or 2x are used, some other means must be employed for dispensing them. Fresh plants contain juice (which is mainly water), and the active principles of many plants require some water for their solution.

To those who mainly use the attenuations in practice the Homœopathic Pharmacopœia of the United States provides a simple, uniform and exact method of notation by which the tincture and every dilution made from it show the quantity of the crude drug which they contain. The tincture \emptyset being $\frac{1}{10}$ or 1x, the first dilution made from it is the 2x, or $\frac{1}{100}$ of the crude drug.

To those who use drugs mainly for physiological effects (and there are such in the homœopathic school), the new pharmacopœia offers uniform standard tinctures which are second to none; for, if exception is made in favor of assayed tinctures, it would apply only to tinctures made from dried plants, as the special activity of tinctures made from fresh plants is probably equal to any benefit derived from assaying. The relative activity of a fresh-plant tincture in successive years could be ascertained by testing it upon animals. This might be of advantage in the case of aconite, digitalis, and some other poisons.

Some physicians are always asking for strong preparations, and think that concentrated tinctures and fluid extracts are to be preferred to ordinary tinctures. For the benefit of such I quote from Prof. Sollman's work, elsewhere referred to. In speaking of tinctures he says: "The tinctures are probably the best, since the quantity of solvent is sufficiently large to insure complete exhaustion of the drug and to keep the principle in solution; they also avoid the necessity of heat." In reference to fluid extracts he says: "They present a definite relation to the drug (1 c.c. equals 1 gm.); but this is merely of pharmaceutic importance. On the other hand, the heat which must necessarily be used in their preparation is never beneficial. On account of their concentration, precipitates are apt to form on standing; and, while these are often inactive, they may contain the active principles. They are also much more subject to precipitation on mixture with other liquids, and the dose is usually so small that they require some such admixture."

Lastly, a new class of liquid preparations has appeared and found favor among those who are always ready for the so-called "strongest tinctures." These are called "fluids," and, according to statements, are solutions of dried plants (carefully selected) in 95 per cent. alcohol in the proportion of one part

of the plant to two parts alcohol. It is claimed that by the employment of repercolation the liquids resulting are at once the strongest and best solutions of the drugs.

From what has been said about the value of the tincture, it is easy to see the inferiority of these new preparations.

In the first place, to use strong alcohol as a universal solvent would be to leave undissolved the principles of many plants. Water will ever remain our greatest solvent, and cannot be omitted without loss of strength (except in certain instances) in the preparation of liquid drugs from plants.

In the second place, the proportion of solvent used (two parts to one part of plant) is entirely too small to exhaust the drugs, even using the method of repercolation which, by the way, is now employed in making some fluid extracts. The privilege of pouring alcoholic solutions over globules and disks without dissolving them is poor compensation for inferior preparations.

Let us be careful, in our pharmaceutical wanderings, not to undervalue our best gifts, and even discard them for inferior ones.

ON SOME OF THE DIFFICULTIES ATTENDANT UPON THE DIAGNOSIS OF LYMPHATIC ENLARGEMENTS.

BY CLARENCE BARTLETT, M.D., PHILADELPHIA.

(Read before the Washington (D. C.) Homœopathic Medical Society, December 14, 1901.)

WHEN, recently, there was presented in my hospital service a series of cases of unusual character presenting enlargement of the cervical lymphatics as their prominent feature, the thought was suggested that I use them as the text of my paper. But inasmuch as they would serve as illustrations of but a limited number of a highly important class of cases, I decided to refer to other cases observed less recently, and to address you "On some of the difficulties attendant upon the diagnosis of lymphatic enlargements."

The vast majority of cases of enlarged cervical lymphatics presenting themselves to practitioners are in infants and children. For many years it was the custom to designate such

cases as "scrofulous." At the present day, the term "scrofula" seems to have gone out of existence in great measure, and now it is not unusual to hear such cases of glandular enlargement referred to as "tuberculous." There can be no doubt that many of these cases are, as claimed, tuberculous. But we believe that the positiveness with which "scrofula" and "glandular tuberculosis" are accepted as synonymous is not warranted by clinical facts. I say this despite the high authorities who have promulgated such a dictum. Thus we find Osler saying, "Scrofula is tuberculosis"; and Louis Starr, in his chapter devoted to the examination of sick children, remarks that the discovery of enlarged lymphatic glands suggests tuberculosis or hereditary syphilis.

While the general abandonment of the term "scrofula" to designate constitutional conditions characterized by enlarged lymphatic glands was a distinct advance in clinical medicine, the too general substitution of "glandular tuberculosis" is to be deplored. The underlying cause of enlargement of the lymphatic glands is found in infection within the area drained by the lymphatic vessels which are received by the enlarged glands. All infections are not equally active, in this respect, and all persons are not equally susceptible. In some instances the history of causes producing such infection may not be forthcoming; or, the history being obtainable, the irritation seems to be entirely inadequate for the production of such results. Take, for example, the following cases:

G. P. W., aged 8 years, received a very small cut beneath the outer canthus of the left eye. The physician summoned irrigated it with a bichloride solution, inserted one suture, and applied a dressing of bichloride gauze. The wound healed very promptly; but there appeared an enlargement of the lymphatic glands in front of the left ear. This proved resistant to treatment. I first saw the case about four weeks after the appearance of the glandular enlargement. Iodide of arsenic 2x four times daily, and applications each evening of antiphlogistin, produced rapid disappearance of the tumors. This was undoubtedly a case of simple adenitis. Tuberculosis certainly did not enter into its etiology.

R. B. W., aged about 60 years, physician, bruised his left knee. Shortly afterwards there appeared a glandular enlarge-

ment in the left groin below Poupart's ligament. His temperature continued somewhat above the normal (99° F. to 100.5° F.) for several weeks. This case was seen in consultation with Drs. Wm. H. Keim and W. B. Van Lemnep. Owing to the way the enlargement had resisted well-selected treatment, and the apparent impossibility of infection by an injury which had not broken the skin, I inclined to the view that the lesion was tuberculous, and favored enucleation. This advice was not followed. The case ran a chronic course over a couple of months, when suppuration ensued. The abscess cavity gave none of the ordinary appearances of a tuberculous lesion. The patient is now well, fourteen months after the healing of the wound.

The conditions existing in the mouth and throat are such that infectious processes are very liable to find their inception in these cavities. If lymphatic involvement ensues, the affected glands are those of the neck and submaxillary region. In many instances the original infection is an innocent affection from a prognostic standpoint, such as carious teeth, stomatitis, tonsillitis, and pharyngitis. Many of the acute infectious diseases likewise produce these glandular tumors, especially measles, scarlatina, roseola, varicella, variola, mumps, diphtheria, whooping-cough, r  theln, and glandular fever. Of the chronic infections, tuberculosis, syphilis and malignant diseases are important etiological factors of lymphatic enlargements. There should be no difficulty whatever in determining whether or not the glandular tumor originated in a local condition of the mouth or throat, as these parts are readily accessible to examination. When these can be excluded, it is time to consider the more serious possibilities of tuberculosis, syphilis or malignancy. In many instances it is not possible to be positive in one's diagnosis until the case has continued for a sufficient length of time to make a simple adenitis an impossibility. In other cases, in which the difficulty is purely local in the beginning, secondary tubercular infection takes place.

To what category the glandular enlargements appearing in children subjected to bad hygienic surroundings, as filth, insufficient food, and foul atmosphere, are to be relegated, is not entirely clear. In the vast majority of cases they are undoubtedly tubercular. Their disappearance under proper general

and medicinal treatment does not antagonize this view, for it is universally admitted that the infection in glandular tuberculosis is the mildest variety of that disease.

The clinical features of a tubercular adenitis can hardly be said to be distinctive. In the majority of cases the glandular swellings are the only symptoms, which are not infrequently bilateral. They usually develop gradually. They may cease their progress for a time, and then once more progressively enlarge. They may be painful and tender, especially during those periods in which they are increasing in size. Most of the cases sooner or later undergo suppuration. As to their relationship to future tubercular processes, clinicians are undecided. It is recognized that but a small percentage of the patients subsequently develop pulmonary disease. Too much should not be said respecting this point at present, for it is evident that the more painstaking the care with which such statistics are prepared, the larger will be the number in whom pulmonary disease appears. The assertion that tubercular adenitis exerts a prophylactic influence against subsequent tubercular infection, although supported by some few high authorities, is most emphatically lacking the confirmation which should be received for so important a statement. Undoubtedly, in some instances, tubercular adenitis acts as a focus for general infection—sufficiently so, indeed, to call for great discrimination in their care and treatment.

The application of the term “scrofula” to conditions other than tubercular is unfortunate, as tending to obscurity and inaccuracy of diagnosis. This remark applies especially to hereditary syphilis. The following case affords a good illustration:

G. M. J., aged 38 years, presented himself for treatment June 25th of the present year. He had considered himself as in good health until the autumn of 1900, at which time he experienced rheumatic pains, so-called, in the left elbow-joint. These pains were continuous, and so severe as to require anodynes; they grew gradually worse until, in April of this year, the joint became rigid and flexed. He had consulted a surgeon, who had broken up the adhesions under anæsthesia. The affected arm showed a moderate degree of muscular atrophy. He advanced several theories to account for the illness. Inquiry

as to his previous state of health disclosed that he had suffered from what was diagnosed as scrofula, between the ages of 2 and 10 years. He exhibited scars about the right femur and left humerus, which had been the points for discharge of dead bone. Hereditary syphilis was suggested as the proper diagnosis, and iodide of potassium prescribed in 20-grain doses three times daily. Improvement began in a few days, and at the end of one month the patient was entirely free from pain, and the affected elbow-joint exhibited but slight rigidity.

The following case presents suggestions of syphilitic and tubercular possibilities: Mr. D., aged 41 years, was referred to me October 2, 1896. During the previous August, while at the seashore, he was taken with a paroxysm, in which the left side of his mouth twitched. Following this, the jaws began to work as if they were biting on something, and then he lost consciousness. He came to in the course of a quarter of an hour. The second seizure came on September 27th, while he was sleeping sitting in a chair. It was preceded by severe headache and nausea. In this attack he was found convulsed on the left side. He did not regain consciousness this time until forty-five minutes had elapsed. He acknowledged that he had not felt well for several months before the first convulsion; that he had spells of numbness in the left leg, lasting from a few minutes to half an hour. For five or six months he had had severe headaches, situated mostly in the right temple. He denied syphilis. The fundus was normal. Both knee-jerks were greatly exaggerated. The urine contained neither albumin nor sugar. He had scars on his neck, the result of glandular abscesses when a child. Iodide of potassium was prescribed in doses of 15 grains three times daily. The patient had one paroxysm in October, succeeding which he had none until September 2, 1898, after absenting himself from observation and treatment for nearly ten months. The iodide was then resumed in the same doses as before. About this time he was taken with severe pulmonary hæmorrhage, with fever and emaciation. But no alteration was made in the treatment. Improvement was as rapid as before. Since that time the patient has had no seizures of any kind, and he is free from signs and symptoms of pulmonary disease. That potassium iodide cured him I have no doubt. If the patient has had syphilis, I believe him to be honest in his denial. And

yet, when we come to investigate his family history, we find that of the best. His mother is still living, and his father died at the age of 83, but a few months ago.

The following case of generalized lymphatic enlargements is hard to place. My first impression was that it was syphilitic, but inasmuch as it failed to be benefited in the least by treatment, and the conditions have remained identically the same over a period of five years, I feel obliged to abandon that idea: Mr. L., aged 21 years, consulted me in April, 1896. He gave a history of a sore on the penis one year before, and of enlarged lymphatic glands in the groin for the preceding nine months. The enlargements were not at all large—not sufficiently so to be visible. Further examination disclosed the presence of numerous enlargements of the lymphatic glands all over the body, axilla, neck, above the elbow, and in the back of the neck. There was no history of an eruption, nor of mucous membrane complications of syphilis. An examination of the blood six months later gave no clew. Treatment was continued for nine months, when he disappeared. He consulted me again this past summer for herpes preputialis. His glandular enlargements were exactly as they were when I saw him last, four years ago. The general appearance of the patient is such as one would expect to find in a tubercular subject. But other than being of a highly nervous temperament and the glandular enlargements, he is in first class health. At one time the thought obtained that he might be suffering from the initial stage of Hodgkin's disease, but time has proven the falsity of that idea.

John R., aged 56 years, I first saw July 12, 1901. At that time he gave a history of excellent health until about three weeks before. He then noticed a swelling of the left arm and hand, and a varicose condition of the veins of the upper arm. At about this time there appeared an enlargement in the supraclavicular region on the left side. He remarked that this tumor started as a group of pea-sized bodies, which at one time could be readily separated, and were freely movable under the skin. He also complained of hoarseness. I did not have an opportunity of examining him thoroughly until October, when he was brought to the Hahnemann Hospital by Dr. Thomas C. Imes, whose patient he was. The history as given above was then elicited. The patient's family history was good, and he

denied syphilis. Both arms were highly œdematous. The walls of the thorax posteriorly were in a like condition, though to a minor degree. A band of varicose veins extended around the lower portion of the chest at about the level of the ensiform cartilage. He was suffering from intense dyspnœa and severe intrathoracic pain. Above the clavicle on the left was a large tumor (it could well be compared, in size, to a moderate-sized orange) adherent to the skin and subjacent tissues. At its apex it was discolored a deep bluish black, and the central point of the discoloration suggested early destructive changes. On the right side there was a bunch of enlarged glands rising in the supraclavicular space. Percussion disclosed large areas of consolidation in the upper portion of the left chest anteriorly. Posteriorly, percussion dulness was general, and extended below the level of the scapular angles. The spleen appeared to be normal in size. Auscultation showed entire absence of respiratory sounds in the upper half of the left chest. Throughout the remainder, loud moist râles were present. The left vocal cord was found by Dr. Harry S. Weaver to be in the cadaveric position, owing to paralysis of the recurrent laryngeal nerve on that side.

The diagnosis made at this time was sarcoma of the mediastinum, with secondary involvement of the supraclavicular glands on both sides. The primary tumor evidently compressed the ascending vena cava, causing œdema of both arms, and upon the root of the left lung obstructing a main bronchus. The possibility of Hodgkin's disease was suggested but dismissed, because of the discoloration of the skin over the glands, their tendency to disintegration, and because of the absence of splenic enlargement. Two weeks later, examination discovered some splenic enlargement. Then, thinking that I had been mistaken in my first examination, I entertained the possibility of Hodgkin's disease very seriously. While it is very unusual for the glandular tumors in that affection to break down, nevertheless there is always that possibility, especially from secondary infection. The patient was given arsenicum iod. 2x, one tablet every three hours. As a result, there was a remarkable improvement in all of his symptoms. The œdema of the arms and back disappeared entirely, and air entered freely into the left lung, and the loud, moist râles disappeared. After he had been in the

hospital five weeks he was taken suddenly with dyspnoea, and with all the signs of œdema of the lungs, and died in a few hours. The autopsy, performed by Drs. J. J. Tuller and S. W. Sappington, discovered a primary sarcoma of the mediastinum, with secondary formations (recent) in the spleen. The autopsy disclosed that the principles upon which the first diagnosis was made were entirely correct. It also gave a good reason for the discrepancies in the examination of the spleen at different periods. Looking at the case in the light of the post-mortem examination and the clinical picture, it hardly seems possible that any other condition than malignant disease within the mediastinum could have been entertained.

About fifteen years ago, Mr. J., aged about 60 years, presented a history of obstinate vomiting for several weeks. He also had hard, nodular enlargements above the left clavicle. His cachectic appearance, together with the vomiting, led to the diagnosis of gastric carcinoma, although no tumor was then discoverable in the region of the stomach. It was about this time that a German clinician directed attention to supraclavicular enlargements of the left side as one of the symptoms suggestive of gastric carcinoma.

Quite recently, J. R. F., aged 38 years, was brought to the Hahnemann Hospital with the following history: He had contracted syphilis two years before, which, however, had given him but little trouble. In June he began with enlargements of the lymphatic glands of the neck and axilla, and these had increased in size until the present time. The patient's general condition was most serious. His breathing was dyspnoic to an intense degree. Loud, moist râles were audible at a distance. Percussion and finer auscultation were impossible by reason of the great œdema of the walls of the chest. Large bunches of lymphatic glands existed in the neck on both sides, in the axillæ, and in the groins. The axillary enlargements were beginning to ulcerate, probably because of the application of poultices, applied by the previous attendant. He had already, so it was stated, undergone a pretty radical anti-syphilitic treatment without any result. The patient died within twenty-four hours after entering the hospital. There can be no question, I believe, concerning this being a case of Hodgkin's disease. The history of a syphilitic infection and the rapid course

offered another suggestion, which, however, was negated by the failure of anti-syphilitic measures and the enormous size of the glandular tumors.

While syphilis is capable of producing general lymphatic enlargements, they never attain any great size. Occasionally, gummatous formations may produce great enlargement of single lymphatics. It was unfortunate that an autopsy was not permitted.

Another case of Hodgkin's disease to which I may here refer was that of an old personal friend, aged 55 years. The disease made rapid progress, and the patient retired to the wilds of Pike county, Pa. There I chanced to meet him. Since seeing him in Philadelphia there had appeared a large carbuncle on the back of his neck, which the local physician was treating, in true old-fashioned style, with poultices. When I left for home, the patient's condition looked very much as if he would die within a few days. While attending a banquet the following winter, a voice called across the table, "Not dead yet, Doctor," and there was Mr. W., to all outward appearances a well man. He still had some small glandular enlargements, but they were not prominent. He remained in good health for two years and then suffered a relapse, and died last spring. Did the carbuncle temporarily stay the course of the Hodgkin's disease? Or was the improvement one of those mysterious remissions in the course of that inevitably fatal disease? Or was there a mistaken diagnosis? In view of the numerous authorities who had agreed upon the nature of his case, the latter seems unlikely.

The diagnosis of Hodgkin's disease is always a difficult matter. Prominent authorities have stated that one should say that "he diagnosed the case as Hodgkin's disease," and not that the case in question is one of that affection. The conditions with which it may be confounded include a general glandular tuberculosis, sarcoma, carcinomatous lymphatic enlargements, and leucocythæmia.

First, as to the differentiation of tuberculosis and Hodgkin's disease. When the physical signs and rational symptoms of pulmonary tuberculosis are present, there is not the slightest difficulty in establishing the true nature of the glandular tumors. But this is rarely the case. The writer can recall

but one case of phthisis seen by him in which lymphatic tumors were present, and these suppurated early after their appearance. The family history and the family tendency of the patient of course count for considerable. In the early stages, the glandular enlargements of Hodgkin's disease are smooth, hard tumors, freely movable, and not adherent to adjacent parts. They increase in size gradually, remaining hard throughout, without any tendency whatever to destructive changes. The tuberculous glands, on the other hand, are inclined to be tender to the touch, and ere long break down and suppurate. The inflammatory changes cause them to become adherent to each other, and thus they form one solid mass. Naturally, the skin overlying the gland shows the discoloration incident to the inflammation beneath. Enlargement of the spleen appears early in Hodgkin's disease, and is an important diagnostic symptom.

From carcinomatous enlargements, Hodgkin's disease is to be differentiated by the stone-like hardness of the tumors in the former, and by the possibility of discovering symptoms which point to the presence of a primary tumor in the area tributary to the enlarged lymphatics.

The differentiation of malignant sarcoma of the lymphatic glands and Hodgkin's disease is regarded by high authority as next to impossible. The points upon which we may rely for their recognition have been stated by Bramwell as follows:

"The fact that the lymphatic enlargement is limited to one or more groups of glands which are in direct anatomical continuity; that the lymphatic swellings directly invade the surrounding tissues; that such organs as the mamma and testicles are affected; and especially that the lymphatic enlargements are secondary to a primary tumor in these or in some of the internal organs, and that the spleen is not enlarged, are in favor of true malignant sarcoma of the lymphatic glands, rather than from Hodgkin's disease.

"*Vice versâ*, widespread enlargement of several groups of glands in different portions of the body; the absence of a primary tumor; enlargement of the spleen; the early development of cachexia implication of the tonsils and other organs in which lymphoid tissue normally abounds, are in favor of Hodgkin's disease.

"The differential diagnosis of Hodgkin's disease and of true

malignant sarcoma is especially difficult,—in fact, impossible,—during life, in many cases in which the glandular enlargement is internal, *i.e.*, in which the bronchial and mediastinal glands are affected.”

Before closing these remarks, I cannot refrain from reporting a most singular case in which remarkable, I might say unexplainable, phenomena ensued upon the removal of an enlarged tuberculous lymphatic from the right side of the neck by a local surgeon.

Mrs. C. A., aged 24 years, consulted me February 12, 1898, at the suggestion of a medical friend. She stated that she had two operations for the removal of enlarged glands in the neck, two years ago. The operations were performed about one month apart. The wound of the first operation healed very promptly, but the tumor returned. When the opening was made for the second operation, there appeared a flow of a clear, watery fluid, apparently saliva. The wound was kept open for some time. After eating, there always appeared a free discharge of a saliva-like fluid. The wound eventually closed; and now comes the remarkable phenomena. Whenever eating, especially some sour substance,—as a pickle,—the right cheek flushed up, becoming a very bright red, and at the same time there began an exudation over the cheek of a fluid, which in composition corresponded to sweat. This flow was so profuse that it necessitated the keeping of a napkin on the face during meals. During the six months I had the patient under observation the symptoms remained as in the beginning. My predecessor in the case had already exhausted every conceivable procedure for its cure, and it was only sent to me as a clinical curiosity. A search of medical literature for similar cases resulted in finding but one other, reported by Mr. Parkes Weber, of London. His case differed from mine only in the absence of a saliva-like discharge at the time of the operation.

HOW THE BUCKEYE AFFECTS THE HEART.

BY T. C. DUNCAN, M.D., CHICAGO.

THE only condition that seems to bring *æsculus* to the mind of the average practitioner is that of hæmorrhoids. That this drug has any value in any form of cardiac disease would only occur to those who would trace the grave effects of an obstructed portal circulation upon the heart and vascular system in general. Let us look at the reported action of *æsculus h.* upon the "heart and pulse":

"Twitching over the region of the heart" is italicized. That is doubtless thoracic, dependent upon spinal hyperæmia. So is "frequent stitches in region of heart." "Darting pains in the region of the heart, with fullness and palpitation," may be also.

"Constant dull, aching, burning pain in the region of the heart" may be myalgic. "Severe neuralgic pain in region of heart, so painful as to arrest the breath (lasting 10 minutes). Neuralgic pain in region of heart lasted over 1 minute, with frequent pains in the epigastric region. Very frequent neuralgic pains in the region of the apex of heart and the stomach. Frequent sharp neuralgic pains in the region of heart, with great burning in the same region. Occasional neuralgic pains in the apex of heart and forehead. Sharp pain in region of apex of heart. Frequent pains in region of apex of heart and between the shoulders." These symptoms may be all of spinal origin and myalgic. But these are cardiac: "Frequent pains in apex of heart. Action of heart full and very rapid. Heart's action very rapid and heavy; would jar me while lying down, and could feel the pulsation all over the body." That sort of action would develop hypertrophy. Then comes: "Palpitation of the heart. Frequent attacks of palpitation. Periodical palpitation of the heart. Severe periodical palpitation, with great anxiety."

These point to periodical obstruction somewhere.

The pulse may be soft and weak, regular or frequent, full and hard. There is fever with this drug when the pulse may be 90, 127 or 130. The chilly feeling begins in back; runs up

and down, as in hyperæmia. Relief comes through perspiration, but chiefly by the bowels, with the storm-centre in the rectum. The history of the case must decide in the selection.

SOME THERAPEUTIC HINTS ON HYDRASTIS CANADENSIS.

BY JAMES C. STIRK, M.D., PHILADELPHIA.

(Read before the A. R. Thomas Club.)

THE remedy presented for your consideration to-night is one frequently overlooked by the general practitioner; and yet, having such decided value in the treatment of catarrhal affections of mucous tracts, it rightly deserves our earliest thought when prescribing for these diseased conditions.

Beginning with the nose and throat, we find its action almost specific in acute and chronic catarrhs, where the discharge is thick, yellow or greenish, and associated with loss of taste and smell. Discs, saturated with equal parts tincture of hydrastis and pulsatilla, will cure the great majority of these cases. In catarrhal affections of the stomach it is equally valuable, especially where there is great accumulation of gas and a sense of heaviness or weight after meals. Here it can be advantageously combined with tincture of *nux vomica*, and we have one of the most reliable remedies in the treatment of the various forms of catarrhal gastritis. Being a valuable hepatic stimulant, it is of much service in the treatment of catarrhal conditions of the gall and cystic ducts when associated with jaundice. Excellent results are also obtained in the treatment of vesical, vaginal and uterine catarrhs. Here the local use of 1 drachm of the tincture, dissolved in a pint of warm water, and used as a vaginal douche or injected into the bladder, often proves curative in chronic and obstinate cases. When possible, the internal and topical use of the drug should be combined. In gynecology, its alkaloid-hydrastine is of recognized value as a uterine hæmostatic. In chronic inflammations and ulcerations of the skin and mucous membrane, the internal use of hydrastine, in 1-16th to 1-4th gr. doses, three or four times daily, combined with the local application of the drug in the strength of 5 grs. to the ounce of water, often cures the most stubborn cases.

TREATMENT OF VARICOSE ULCERS BY HAMAMELIS INTERNALLY AND
IN AN OINTMENT.

BY FRANK H. PRITCHARD, M.D., MONROEVILLE, OHIO.

VARICOSE ulcers often give one a great deal of trouble in their management, particularly the sluggish ones, for they refuse to heal. The oozing secretions destroy the feeble granulations, and the little islets of epithelium fade away and are cast off by the foul purulent exudate. I have had some trouble in treating such ulcers, but I have thought out a scheme of treating them which, though it has nothing original in it, yet it has a feature which might be worthy of attention. Hamamelis is and has been praised as a general and local remedy in such states by members of all schools. In treating these cases one will be struck with the inactivity of the usual antiseptic solutions in cleansing varicose ulcers. In fact, they do not do it. The glue-like, tenacious secretion sticks to and covers the ulcers like a coat of varnish, hindering any remedy acting locally. For this reason I have ordered the ulcers to be washed with a solution of soda in water; for example, a teaspoonful to a pint of boiled rain water. Then I have found useful an ointment made by rubbing up about a drachm of the dry extract of witch hazel with an ounce of vaseline. This is applied to the ulcer in a fairly thick layer. Over this is laid a small, flat and soft sponge, such as children use in school for their slates. This is moistened in any convenient antiseptic solution. The soda solution softens and disintegrates the tough secretions of the ulcer; the witch-hazel ointment acts as a very useful local remedy, almost specifically, it seems to me; and the sponge serves to take up the excess of the fluid oozing from the surface of the ulcer instead of allowing it to stagnate amongst the granulations, rendering them feeble and lifeless. It also acts as a serviceable local irritant, whose action is by no means to be overlooked. If the ulcer be irritable, the sponge may be left off until the hamamelis unguent has rendered the ulcer tolerant of pressure. Over the whole, naturally, a bandage, preferably of cotton flannel, is applied.

As I first said, there is not much new in this method, except in the way in which it is carried out. The ointment of hamamelis is certainly a very useful local application in varicose ulcers, and, at the same time, the tincture of the same drug may be administered internally. The soda solution has been found by me much superior as a detergent to the ordinary antiseptic solutions, which run over the varnish-like coating of the ulcer and leave it unaffected. The sponge soaks up the excessive oozing secretions, preserves the granulations from stagnation and maceration, and at the time acts as a local stimulant.

By these measures I have succeeded in healing a number of obstinate and sluggish varicose ulcers which had made the bearers miserable, and me, before I knew of this method, to wonder how I could ever cause them to heal.

FEAR AS AN ELEMENT OF NERVOUS DISEASES AND ITS TREATMENT.—Punton (Kansas City) writes a very interesting article on fear as an element in nervous diseases. He argues that fear, to a certain extent, is present in all individuals; it merely conforms to the instinctive power, always existing in man and animals, of self-protection. Its manifestation does not depend so much upon the existing power producing it as the receptive and restraining power of the individual. In some cases the emotional element, or fear, is controlled by the will, or, in other words, the inhibitory power; while in other patients both these elements may be weakened, or even paralyzed. All fear has for its foundation a presentiment of danger. The manifestation, clinically, may be objective or subjective, involving motor, sensory, reflex, trapezie, secretory, visceral and psychical nervous mechanism, with varying intensity. Fear, under certain conditions, when within certain limits, may be a physiologic function, similar in a great extent to that of its opposite—joy; but beyond these limits it ceases to be normal, and becomes pathologic. In some instances fear has a weakening, in others a stimulating influence. Morbid fear, or pathophobia, as an element of nervous disease, gives the disease a more serious aspect. Especially is this true in neurasthenia; and in its more severe forms it is a necessary element of psychic neurasthenia. When carried to an extreme degree, it generally ends in impulsive acts. As to treatment, Punton advises isolation of patient, but not too long in one locality, as the patient may become accustomed to the new associations. Having isolated the patient, the next powerful therapeutic agent to be used is suggestion; in other words, all the influences included in the term hypnotism. The physician, during all the treatment, should endeavor to make his patient become more self-confident and self-reliant. Massage, electricity, hydrotherapy, diet and drugs, including hypnotics and stimulants, if necessary, may be used with great advantage. Of course, if any pathologic conditions are associated with the morbid fear, these conditions should be treated in conjunction with the pathophobia.—*Journal of American Med. Assoc.*

EDITORIAL.

THE HEART OF THE CHILD.

IN spite of the fact that disease of the heart is of frequent occurrence in early life, and that upon the integrity of this organ depends not only its own proper development, but also the normal growth and development of the whole organism, there are comparatively few of us who think it worth our while to investigate the condition of the heart of a child with the same care and thoroughness which we devote to an examination of an adult. This is no doubt due both to the long-suffering patience usually required to put the child into a fit frame of mind to submit quietly to the examination and to the deceptive findings in many cases. "The child's heart holds as many secrets as the man's, and is even more deceiving." It needs, therefore, if anything, more careful and painstaking investigation and observation, as Dr. Lees, of London, pointed out in his presidential address on "The Heart of the Child," delivered before the Harveian Society in January.

In view of the immense amount of work which lies before the child's heart, if it survive through a life of fifty years—amounting to the raising of 1,500,000 tons to a height of one foot—the condition of the organs and an early recognition of any disease or defect becomes of even greater importance than in the case of an adult. Added to this is the fact that, being but imperfectly developed, early recognition of any departure from the normal condition will go far towards its cure or amelioration, since there is more hope in the application of therapeutic measures at this early stage than later in life.

Dr. Lees, therefore, makes an earnest plea for the most careful study, accurate investigation and patient observation of the heart of the child, and points out very clearly how this can and should be carried out.

The methods to be employed in the examination are the same as in the case of an adult, and, barring the difficulty aris-

ing from the refractoriness of the little patient, which may usually be overcome by the tactful physician, can be carried out with satisfactory and accurate results.

He wisely recommends that palpation and percussion, with warm and gentle hands, should always precede the use of the stethoscope, for in this way much valuable information can be secured without alarming the patient, who will gradually, at the same time, be prepared for the application of an instrument which would have been likely to terrorize him had it been brought into requisition in the beginning.

By quiet palpation the cardiac impulse and strength of the left ventricle can be ascertained, and by shifting the hand to the epigastrium the presence or absence of any impulse of the right ventricle can be determined. If it be found, then there is either some congenital malformation or there is some disease of the lungs or of the left heart. The hand, gliding on farther to the hepatic region, can recognize the resistance of an enlarged liver, and a single tap on a finger below the costal margin will confirm or correct the observation.

The object of percussion is to discover the exact size of the heart, and this can best be done, as Dr. Lees insists, by the lightest possible percussion with the finger only, using the terminal phalanx of a finger of the left hand as the pleximeter, and letting no other part of the hand touch the chest-wall. This is an important caution, since, on account of the known great resonance of the child's thorax-walls, any other method will produce confusion or inaccuracy by the conduction of resonance from other points than the one to be percussed.

By gradually sliding the percussed finger from the mid-axillary line towards the sternum, the beginning of the cardiac dulness can readily be determined, and will be found a little to the left of the position of the impulse. Next determine whether the dulness extends to the left of the nipple itself, and, if so, to what amount in the nipple-acromial line.

He next ascertains the size of the right auricle, and draws attention to the fact that the dulness due to this structure may always be detected, even in the normal heart, in the fourth right intercostal space. The third space ought to be resonant, he says, quite up to the sternum, and in the fifth space the hepatic dulness alters the note; but in the fourth space the

dulness of the right auricle is present for about a finger-breadth in an adult, and rather less in the child.

Dr. Lees says: "The accurate determination of the size of the right auricle is a matter of the greatest importance, and often indicates at once the necessity for leeches to relieve distention. The suffering due to a distended bladder a medical man would promptly relieve, but that due to a distended right heart is allowed to remain because his percussion is not accurate, and bleeding is out of fashion."

He finally proceeds to the use of the stethoscope, which should be as simple as possible. "All you want is a small and simple ivory cup as a chest-piece, with two rubber tubes from it to two ivory ear-pieces. If these fit the ears properly, there is no need for any spring." Of murmurs due to congenital malformations he has found the most frequent to be a systolic murmur, often very loud, loudest at or just below the junction of the left fourth costal cartilage with the sternum, probably often due to an incomplete cardiac septum. The next most common is also systolic over the pulmonary artery, loudest at the second left cartilage, and conducted towards the auricle, indicating congenital obstruction of the pulmonary artery. He acknowledges that it is often impossible to diagnose the exact condition of a malformed heart by physical examination, since, in some cases, there may be no murmur at all. Congenital murmurs are systolic in turn, presystolic or diastolic ones being exceedingly rare.

He calls attention to a systolic murmur, sometimes accompanied by slight irregularity of the heart's action, occurring not infrequently in healthy children, and not indicative of any organic disease. It is a low, soft, short murmur in the tricuspid region, best heard about half way between the left edge of the sternum and the nipple line, usually becoming inaudible at a short distance to the left of this line.

The right heart is mainly affected by congenital malformations, but secondarily in connection with acute or extensive chronic disease of the lungs, or disease of the left heart. Hence he insists most strenuously upon the duty of the physician to keep track of any distention of the right heart, not only in pneumonia, but also in acute and chronic bronchitis, in whooping cough, broncho-pneumonia, emphysema, and in asthmatic

attacks. In a primary attack of rheumatism no dilatation of the right heart may be noticeable, nor in chorea; but if the attacks recur, which they are prone to do, then it will manifest itself, if severe and sudden, by dyspnœa; or, if more gradual, only on percussion. The consequent enlargement of the liver will thus become evident, and the condition will become a dangerous one, "but relief may be given by prompt venesection or leeching."

In the examination of the left heart palpation will have revealed the strength of the ventricular muscle, while any enlargement can be determined by careful percussion.

From a number of observations, Dr. Lees concludes that in normal children the left border of the cardiac dulness is usually distinctly internal to the nipple-line, that it may sometimes reach it, but that it rarely goes beyond it, and that any extension beyond it, therefore, must be regarded as suspicious. Enlargement of the left ventricle is found in diphtheria, in rheumatism and chorea, in influenza, less in pneumonia, in typhoid fever, in tuberculosis, and even in anæmia and debility, and in renal disease, due probably, in a measure, to the deleterious effects of toxins and poisonous products circulating in the blood.

In acute and subacute rheumatism an enlargement of the left ventricle, with weakening, seems inevitable. As the attack subsides, the line of dulness tends to return to the normal; but when a murmur becomes audible, the left ventricle remains more or less dilated. He says, very forcibly, "The slightest suspicion of rheumatism should lead to a most careful examination of the child's heart by palpation and percussion; the practitioner who, in this matter, relies solely upon auscultation betrays a carelessness which is almost criminal." He favors the view that in rheumatism we have an actual inflammation of the muscular substance and fibrous structures of the heart, due to the local presence of diplococcal micro-organisms which have been demonstrated by Drs. Poynton and A. Payne in the cardiac valves and muscular walls.

As to the treatment of rheumatism, he insists upon the employment of sodium salicylate in adequate doses, and sodium bicarbonate in double the dose of the salicylate, either in connection with it or alone. To reduce the inflammatory condi-

tions of the heart, he depends upon leeches and ice-bags to the region of the heart.

When the inflammation has subsided and the mechanical effects of the cardiac lesions manifest themselves, digitalis often works wonders. In ventricular enlargement and enfeeblement due to toxæmia, digitalis may be of use, but hypodermics of strychnia are better. In the condition following diphtheria he relies mainly upon atropine subcutaneously, or, where not so urgent, by the mouth.

The address was immensely practical and instructive, and the advocacy of venesection and leeching will at least furnish food for thought.

W. H. BIGLER.

THE HOMŒOPATHIC PHARMACOPŒIA OF THE UNITED STATES.

THE new edition of the American Institute work on Pharmacy is now at hand, and offers an opportunity for again congratulating the homœopathic profession upon the possession of an authoritative Pharmacopœia of which it need not be ashamed, and which places homœopathic pharmacy on an equality with, if not in advance of, that of other schools of medicine.

Its sensible and scientific treatment of the subject will forever put at rest carping criticism of our methods by those who have chosen to consider them visionary, and will compel a cessation of that ridicule which has been heaped upon our so-called "moonshine" potencies. It must also stop those unending arithmetical calculations which have been so industriously circulated from Dr. Holmes' time down to the present.

Of course the greatest gain from this work is the establishment of a standard unit of medicinal strength by which all tinctures, dilutions and triturations may be compared and estimated.

This marks a great and notable advance in pharmaceutical preparations, which, when adopted, as it surely must be, by all English-speaking homœopathists, will render our clinical records comparable and intelligible. Hereafter, when a cure by any dilution or trituration is reported, we may know exactly what strength of drug has produced the result. To-day, when

a result is credited, for instance, to phosphorus 4th x, we are entirely at sea as to the real strength used, inasmuch as some consider the strongest solution possible as the tincture, and make dilutions (1-10) from it up to the 4th x; whereas others, more properly recognizing that phosphorus is soluble in only about 1-1000, mark the tincture the 3d x, and the first dilution (1-10) made from it as the 4th x. How is it possible for such reports to be compared?

The adoption of this standard of strength does not in any way limit the physician in regard to his dosage. He can still use whatever amount of gross drug-substance he desires, or its highest dilution or potency, with the added knowledge that he can know exactly what quantity he is using. This innovation, together with our wonderfully convenient and accurate decimal scale of decreasing dosage, will prove to be so attractive and useful that it will doubtless be eventually adopted by the older schools of medicine.

The fact that these changes may cause pharmacists more or less inconvenience, and perhaps, in some cases, even large pecuniary loss of stock now on hand, should not stand in the way of their favorable acceptance. No innovation can be accomplished without some loss to some individuals. The loss to individuals from the introduction of labor-saving machinery is often very great, but we do not allow that to check progress. Certainly it is unnecessary that any such obstacles should stand in the way of advancement in the noble profession of medicine. It is the province and right of the physician to dictate the kind of drugs he is to use, and to say how they shall be prepared. The agitation of this subject has been going on for years, and any intelligent pharmacist must have foreseen that important changes in tincture-making and in units of strength were impending. It will simply remain for physicians to insist that they shall be supplied with drugs made after the new formulæ, and a sufficient number of drug houses will be found ready to supply the demand.

The substitution of the decimal scale of dilutions and triturations insures more uniform diffusibility of the drug in all preparations, and so provides for even greater efficacy of medicinal action than did the Hahnemannian scale; and, as its markings can readily be converted into the centennial nomenclature, this innovation is not open to criticism.

The recommendation which will arouse the greatest hostility to the new work is its attitude regarding the making of dilutions from the triturations of insoluble substances. Full directions are given for the formation of such dilutions in strict accord with Hahnemann's teachings; but the book does not recommend them, and bases its position upon the present state of scientific knowledge. This is the only dignified and honest way of handling a subject concerning which there is difference of opinion and belief.

The Pharmacopœia takes a safe ground that can lead to no error when it recommends that all insoluble drugs be potentized by trituration, and that only the soluble drugs be used in making the dilutions. Physicians have yet to decide whether a trituration of any given insoluble drug differs in effectiveness from its corresponding dilution. Whether Hahnemann's belief was right, that insoluble drugs become soluble after the 6th x trituration, is in grave doubt, but that drug-substance is held in suspension in such dilutions admits of no question. This fact probably explains their curative power, of which we have ample proof. Whether succussion of such dilutions subdivides drug-particles any further is a point that cannot be settled satisfactorily by present science. The expressions of the editors on the divisibility of matter are personal beliefs, and, as they are stated in foot-notes only, do not in any way hamper the physician or pharmacist who thinks differently.

The fear that the changes recommended will in any way endanger the tenets of Homœopathy is entirely unfounded. The cardinal principle of homœopathic pharmacy is that, for the preservation of the full value of our provings, all drugs shall be so prepared as to reproduce all of their original drug-effects (symptoms) in their entirety. Any innovation in pharmacy which will disturb such action renders its proving worthless. This point the editors of the Pharmacopœia have studiously guarded. In no drug have they suggested a change in its pharmacy which will in any way limit its physiological action. All changes have been made in the direction of greater activity and precision.

Of course the book is not perfect. It does not give sufficient detail of methods advised to enable one who is not already a skilled pharmacist to prepare certain drugs successfully; but it

has accomplished its purpose, and established a basis upon which succeeding editions can be perfected.

It carries with it the authority of our great national society, and it will certainly be recognized by our British friends, as it follows their own Pharmacopœia. Let us hope that every homœopathic physician will demand that his pharmacist shall follow its directions.

E. M. HOWARD.

THE TECHNICS OF NEPHROPEXY.

APROPOS of Dr. Lawrence's excellent gleanings in the February *HAHNEMANNIAN* on the cure of chronic Bright's disease by operation, another article by Dr. Edebohls in the February *Annals of Surgery* will be of interest to those who are following the new fields opened to surgery by the attempts, in hitherto hopeless cases, of increasing the anastomoses between the portal and general circulations in obstructive ascites, together with the hyperæmization of the liver in cirrhosis and the kidneys in chronic nephritis.

The author very justly calls attention to the relationship between right nephroptosis and appendicitis, supposedly due to circulatory disturbance in the superior mesenteric vein, as well as to the frequent coincidence of adnexal, or, more broadly speaking, of pelvic disease. When we recall the vascular and lymphatic connections between the appendix and the broad ligament we can readily understand a portion, at least, of this vicious circle. We can corroborate the above statement in the order named, or inversely; for we have met with cases of extensive pelvic operation, oöphorectomy, salpingectomy, and even hysterectomy, where the symptoms were not relieved until the kidney was anchored. Presumably palpable lesions in the parts removed must have been present, for the operators were men of experience. We have also seen abdominal distress persist after the removal of a diseased appendix, which cleared up after a right nephropexy, and *vice versa* as well. For the latter association the author practices a simultaneous removal of the diseased appendix with the anchoring of the loose right kidney. The appendix is reached through the lumbar wound, to be described later, by opening the peritoneum on

the outer side of the ascending colon, the appendix being found in the usual way by following the longitudinal muscular band. The author, as is well known, is an advocate of inversion of the appendix without ligation, after tying off the meso-appendix. This posterior operation cannot give the access to the organ obtained by the anterior incision, and probably in one in ten cases, at least, the attempt to do so will fail on account of position or complications. Hence the method is only indicated when appendicectomy is incidental to nephropexy.

Another interesting concomitant of movable right kidney is the reference to disease of the bile passages. Whether the former has a causal relationship to the latter is, of course, open to doubt, and depends largely on the principle of "*post (seu cum) hoc, ergo propter hoc*;" yet it should be remembered that by enlarging the peritoneal wound made to reach the appendix, upward, access can be obtained to the duodenum, pylorus, pancreas and gall-bladder, as well as to the common, cystic and hepatic ducts. As regards surgical attack upon these structures, the anterior incision is undoubtedly preferable; but for incidental exploration, even through the intact peritoneum, the suggestion is certainly worthy of consideration.

The author's perfected method of nephropexy, while differing in some respects from that practiced by other surgeons, is based on an extended experience, and has been followed in his hands by the most flattering results. The patient is placed prone upon the table to permit of a simultaneous attack on both kidneys, if desired, the ilio-costal space being widened by the use of an inflatable air-pillow. This position not only favors the protrusion of the kidney, but, if not readily accessible, it can be brought into the wound by rolling the patient down on the cushion by traction on the legs. The incision is a vertical one along the outer border of the erector spinæ muscle, without opening its sheath, from the last rib to the iliac crest; and this can be carried more obliquely toward the anterior superior spine if the space is limited by a long, oblique twelfth rib, or a short, stocky build. The fibres of the latissimus dorsi are separated by blunt dissection in their long axis, slightly inward from below up, the transversalis fascia divided, and the perirenal fat exposed.

It is to be remembered that the ilio-hypogastric and possibly

the ilio-inguinal nerves may be injured, and that this may cause persistent, subsequent, so-called "kidney pain." Such a result may be avoided by drawing aside the nerve or nerves, or by suturing in case of division. The sheath of the quadratus lumborum is next divided from rib to ilium, its cut edges retracting and exposing a large raw area. The kidney and its fatty capsule are then delivered by traction on the latter, blunt dissection, nicking the lower, outer fibres of the quadratus, and by rolling the patient up and down on the air-cushion. The fatty capsule is removed entire, the kidney, its pelvis and the upper ureter explored, and appropriately treated if necessary. The organ can then be temporarily replaced, while the duodenum, gall-ducts, etc., are explored with or without opening the peritoneum, or the appendix is found and excised. The peritoneal wound is sutured and the kidney brought out again. Its capsule proper is stripped about half way back, and two suspension sutures are passed through the reflected and attached capsule on either side, when the organ is replaced. These four sutures are then passed through the abdominal wall, four ends on either side of the incision, and they are tied, after the muscles have been drawn together, fixing the raw kidney against the raw quadratus. A skin suture completes the operation, which can be repeated on the other side at the same or at a subsequent sitting. The kidney is thus anchored in the ileo-costal space, its upper pole extending under the rib as far as the lower one descends inside the ilium. The position is the upright one, and therefore preferable to the frequently practiced attachment at the lower pole, which, not infrequently, is followed by tilting.

The stability of such adhesions may naturally be questioned by those who advocate suspension and pack, or suture and pack. The renal and muscular denudation, however, present broad raw surfaces which must unite extensively during the three weeks of confinement in a supine position as recommended by the author. The method has, besides, the advantages of rapid healing, painless redressing, and the prevention of hernia, although the latter probably depends more on the incision, the "trap door" of some surgeons leaving the abdominal wall particularly weak. In deciding upon failure or "breaking loose," the author considers, as the crucial test, the

fact that a movable kidney can be readily pushed up under the ribs, and if this cannot be done after operation, the organ has been successfully anchored. While theoretically correct, such a hard-and-fast rule cannot be absolutely adhered to. In most cases we are led to operate for certain subjective symptoms resulting from nephroptosis, and if they recur with increasing mobility, we can reasonably conclude that relapse has taken place, even if the kidney cannot be forced up under the ribs from its new position. We would also take exception to the author's contention that the adhesions produced by primary union are as strong and unyielding as those induced by tamponade and granulation. We have more than once re-anchored kidneys which had stretched out the adhesions of a primary union to a considerable length. The division of even so attenuated bands, however, has convinced us of the possibilities of the author's suggestion of nephropexy for chronic Bright's disease, for new vessels were present which were large enough to require ligation. With extensive denudation and broad attachment, such vascularity must be considerable.

For movable kidney alone, if the condition be not part of a general enteroptosis, in connection with appendicectomy, or with the correction or removal of pelvic lesions, as a means of exploring incidentally the bile passages and upper intestine, and, lastly, as a *hopeful* therapeutic agent in the cure of *hopeless* kidney inflammations, the operation of nephropexy deserves the attention of the general practitioner, as well as the surgeon.

WILLIAM B. VAN LENNEP.

EUMENOL AND STYPTICIN.—(Lauges.)—Eumenol (extract from the root of Tang-kui) is used chiefly for dysmenorrhœa of multiparæ, where there is no serious organic defect, and also in too frequent and profuse menstruation in multiparæ.

It is given in tablespoonful doses after meals three times a day for a week preceding menstruation. The severe pains in the abdomen and sacrum were relieved, but recurred in three months, and were cured by repeated doses, amounting to one hundred grams. In one case in chronic endometritis, salpingitis and ovaritis, the profuse flowing was relieved. Excellent results were obtained in a case of hæmorrhage in the fifth month of pregnancy.

Stypticin or the tincture of stypticin (stypticin, 1.0 ; cinnamon, 10.0) has been used successfully for profuse menstruation beginning on the first or second day of the menses.—*Therapeutische Monatshefte*, July, 1901.

GLEANINGS.

LATENT ANEURYSM OF THE AORTA; MASSIVE AND NECROSING PNEUMONIA OF THE LEFT LUNG.—Professor Huchard, of Paris, reports the case of a patient with discrete tubercular lesions of the apex of the left lung, who presented the signs of a vast pleuritic effusion, as complete flatness, absence of the respiratory murmur, abolition of the thoracic vibrations, etc., where the necropsy showed that the patient had no pleurisy at all, but that he was suffering from a massive and necrosing pneumonia due to compression of the pneumogastric by a voluminous, sacculated aneurysm of the aorta, whose presence had been wholly overlooked during life.—*La Semaine Medicale*, No. 48, 1901. (I once saw such a case in the Pathological Institute in Vienna, but here the massive and necrosing pneumonia was due to compression of the left bronchus by a sacculated aneurysm of the size of a small orange, filled with hard clots. The lung tissue was dripping with pus.)

Frank H. Pritchard, M.D.

ANOMALIES AND COMPLICATIONS OF CHICKEN-POX.—Dr. Leon Cerf, quoting Picot's statement that "chicken-pox is always a disease of no importance, which never endangers life," differs from him emphatically. If it develop anomalously, it may even cause death. He asserts his belief in a prodromal stage. The nervous symptoms, spasm, agitation and delirium, may be intense. Besides the actual exanthem of variola, there may be an associated rash, often scarlatinous, and accompanied by fever and various general symptoms. This rash may appear with or after that of the varicellæ. Where this rash coexists he thinks the outlook *less* favorable. The mucous membranes may be involved at the same time, and give rise to rounded erosions, which may be accompanied by stomatitis. The conjunctiva, nostrils and the auditory meatus may also be affected; the genitals are at times involved. A rare though peculiar localization is the larynx with a croup-like condition; *the prognosis is in such cases serious*. The exanthem may be abortive, excessive, or even pemphigoid. There are three different forms of the eruption worthy of note: the hæmorrhagic, the gangrenous and the suppurative. The hæmorrhagic, if slight, is of no great significance, but it may be accompanied by serious hæmorrhages from the mucous membranes. The gangrenous form is characterized by normal vesicles suddenly becoming hæmorrhagic, whose contents dry, leaving blackish crusts and a furrow of demarcation surrounding each; the scab falls off and leaves a greenish-yellow, dirty ulcer filled with pus. The ulcer may extend, and in both depth and width, and expose muscles and fasciæ. Not all the vesicles in such a case become gangrenous, however. The outlook is serious; is not infrequently accompanied by fever, with a typhoid condition. Albuminuria and laryngitis have been observed. This form may be noted in robust as well as in weakly children. It actually has no epidemic character, for one may note that out

of several children affected in the same family one will have the disease in the gangrenous form. This variation pathogenetically is a staphylococic infection. The suppurative variety is also due to staphylococci, rarely to the streptococci. It is most often seen in weakly children who scratch a great deal, have dirty skins, or where the vesicles become infected by the urine or faeces. Nearly all the cases which complicate or follow scarlatina suppurate. The vesicles of chicken-pox often resemble those of the small-pox, and quite pronounced pitting may occur. The general condition may be quite affected, and serious complications, as diffuse phlegmons, furunculosis, subcutaneous abscesses, erysipelas, otitis media, formation of thrombi in the large blood-vessels or even pyemia have been reported.

During the eruptive stage or during convalescence the writer has noticed polyarticular arthritis, mostly of a benign and serous form, though it may be suppurative.

A serious complication to chicken-pox is nephritis, to which Henoch called attention in 1884. Though not so frequent as after scarlet fever, yet it is more frequent than is usually thought. The nephritis may be latent, slight or serious. Pathologico-anatomically the condition is glomerulonephritis.

The chicken-pox may complicate other diseases, most often scarlatina, though it has been noted to occur with diphtheria, whooping-cough, mumps; recurrences are very rare.

The patient should be kept in bed several days; in the house a week, to prevent nephritis. Baths followed by toilet powder and antiseptic treatment of the vesicles are indicated.—*Hospitalstidende*, No. 46, 1901.

Frank H. Pritchard, M.D.

TWO CASES OF LATENT, INFECTIOUS ENDOCARDITIS, ONE PURSUING A SUBACUTE, THE OTHER A CHRONIC COURSE.—Dr. Claude, of Paris, at a recent meeting of the Medical Society of the Hospitals, of that city, related the histories of two cases of infectious endocarditis which are of interest.

The former was that of a man of thirty-six years, who for eight days had been afflicted with intense dyspnoea, with cyanosis of the extremities, albuminuria and subnormal temperature when he entered the hospital. On listening to his chest the râles of disseminated bronchitis were audible over his whole thorax, but no murmur was to be heard over the heart, which sounds were masked by the breathing. Twenty-four hours later he died.

At the necropsy the sigmoid valves of the aorta were found covered with verrucose vegetations coated with a fibrinous exudate, with numerous small ulcers beneath. Bacteriologically a great number of cocci were to be detected, both in the vegetations and in the blood; these were also found in the hæmorrhagic spots with infiltration of embryonic cells, the liver and spleen. The disease was therefore a septic, ulcerating endocarditis of the aorta, with numerous microbic emboli in the chief organs.

The second case was that of a woman of thirty-four years, who was brought to the hospital in a condition of very great prostration and cachexia. It was learned that eight months before she had had an attack of polyarticular rheumatism, after which she had steadily grown weaker. While in the hospital she could take almost no food. She complained continually of abdominal pain; had diarrhoea almost continuously, with intestinal hæmorrhages,

bilious vomiting, etc. She finally died, greatly emaciated, without having suffered from fever at any time while under observation. Auscultation revealed a diastolic murmur at the base of the heart, which was attributed to a former aortic incompetency. The necropsy revealed a complete absence of tubercular ulcerations, which one expected to find in the intestines; the lungs were also free from lesions. The valves of the aorta were discovered to be covered with disseminated vegetations, with a fibrinous exudate covering them: one of these contained a little abscess, in which were a number of fine streptococci, devoid of pathogenic powers. The liver, spleen and kidneys were the seat of lesions of toxic origin—fatty degeneration of the liver cells, islets of interstitial nephritis, etc. One may therefore say that this case was a latent endocarditis which pursued a slow course and ended by bringing about a toxæmia which was the cause of the cachexia to which the patient succumbed.

In the discussion Dr. Beclère said that this form of cachectic endocarditis with a slow course is far from being very rare. He observed a case where the only symptoms were attacks of fever greatly resembling malarial intermittent fever. Only after several months had passed were cardiac collapse, arrhythmia, later asystolia, albuminuria, etc., noted. The patient eventually died.

Dr. Gouget claimed that if one make cultures with these germs exposed to the air, only coli bacilli will be obtained; but if the air be excluded, one will nearly always get a streptococcus, as Dr. Claude describes.—*La Semaine Médicale*, No. 53, 1901.

Frank H. Pritchard, M.D.

DELIRIUM, WITH AN ATTEMPT AT SUICIDE, DURING TYPHOID FEVER.—Dr. Souques reported to the same society the case of a young girl who tried to commit suicide on the sixteenth day of the disease by throwing herself from the window of the second story of a building. She lived forty-eight hours, and related that she jumped out because she feared she would be cut into small pieces or buried alive because she had urinated in bed a few days before. The writer asserts that these delirious states may supervene during typhoid with fixed ideas and oniriques hallucinations, which may give rise to impulsive acts, against which one cannot take too much precaution. Dr. Antony observed that it was not rare to notice melancholic delirium during convalescence from typhoid, and that they are often brought about by the state of inanition in which these patients are. Dr. Joffroy, on the contrary, cited the case of a young girl who, when convalescent from typhoid, seemed to become melancholic from excessive feeding; she was put on a milk and water diet, and recovered.—*Ibidem*.

Frank H. Pritchard, M.D.

THE ORIGIN AND PROPHYLAXIS OF RENAL STONES DUE TO OXALATES.—Prof. C. Klemperer, of Berlin, at a recent meeting of the Medical Society of that city, read an interesting paper on this subject, in which he declares that these stones are more frequent than is usually assumed. Their production is favored by foods rich in lime, as well as by substances containing oxalic acid, as vegetables, and glycocol and kreatinin, which are derived from it, produce it. He recommends magnesium as a solvent, which is present in meat and in the leguminosæ, while milk is not to be advised, as it is rich in lime and poor in magnesium. He therefore would have such patients take magnesium sul-

phate in doses of about two grams a day. Professor Senator thought the stand of Dr. Klemperer well taken, for it would explain the oxaluria of young children who use milk so much.—*Muenchener Medicinische Wochenschrift*, No. 50, 1901.

Frank H. Pritchard, M.D.

THE X-RAYS IN SO-CALLED SPRAINS.—Ross and Wilbert (Philadelphia) present a number of cases of so-called "sprains" where the X-rays showed some variety of bone lesion, such as a fracture of one of the small bones, or an avulsion of a shell or piece of bone corresponding to the attachment of a ligament. These fractures occur near the joints, and frequently communicate with the joint cavity. That this view of the pathology of sprains is a correct one is proven by the fact that, clinically, these injuries are attended with results out of all proportion to the signs and symptoms of the condition. The pathology of sprains has been considered more or less vague, and the results of treatment unsatisfactory. The lesson that this article brings out is to never be too ready to diagnose an injury of this sort as a sprain until the X-rays examination has proven that there is no fracture present. Every case of "sprain" calls for an examination with the fluoroscope, or for a radiograph, if the former is unsatisfactory.—*American Medicine*, January 25, 1902.

Gustave A. Van Lennep, M.D.

SOME INDICATIONS FOR GASTROENTEROSTOMY.—Mayo (Rochester, Minn.), speaking from experience derived from sixty-four operations, gives the following indications: In malignant disease, gastroenterostomy is indicated only if symptoms of obstruction are present. The mortality is from 25 to 50 per cent., and the reason for this lies in the bad condition of the patient. The early cases in good condition need radical treatment, and pylorotomy, etc., on this account, have an even lower mortality than gastroenterostomy, which has no such limitations.

For open ulcer, gastroenterostomy is of the greatest benefit if the ulcer is situated near the pylorus, and it usually is. Under such circumstances the stomach is of normal or increased size, the latter condition due either to obstruction or pyloric spasm. If the ulcer be distant from the pylorus, and the stomach contracted, gastroenterostomy has less value, and the anastomotic opening may close, although the ulcer is usually healed before this takes place.

For benign obstruction, without regard to origin, gastroenterostomy is the operation of choice, the cure being immediate and lasting. Pyloroplasty enlarges the outlet, but if the stomach is very large and pouched, the degenerated muscle fibre may fail to elevate the food to the pylorus, and relief is not always afforded. Gastroenterostomy drains from the lowest point, and is superior in every way to the plastic operation.—*International Journal of Surgery*, February, 1902.

Gustave A. Van Lennep, M.D.

MECKEL'S DIVERTICULUM AND ITS RELATION TO ILEUS.—Theinhaus (Milwaukee) reports the following case of ileus due to a Meckel's diverticulum: Boy, seventeen years of age, who had from birth a reddish-looking, mucus-secreting tumor of the size of a walnut lying on the outer side of his abdomen, which had resisted several attempts at removal by cauterization with different chemicals. When first seen, symptoms of obstruction of the bowels

had existed for five days, with stercoraceous vomiting for three days; temperature, 100° F.; pulse, 110, and that much-dreaded "facies Hippocratica." Operation, though advised on the first day, had been put off by the family. On opening the abdomen, a string about the size of the little finger, extending from the umbilicus to a part of the ileum, was encountered, over which was hanging a large coil of small intestine. The tumor on the navel, together with the skin and the band, was dissected out, and the stump, where the string entered the ileum, was sutured with Czerney-Lembert sutures and inverted into the bowel. The boy recovered.

The author points out the danger of mistaking a mucous membrane on the outside of the navel of a new-born infant, after the umbilical cord has fallen off, for a granuloma, and resorting to the cautery to remove what is thought to be granulation tissue. This no doubt has been the cause of the death of many a child, in consequence of the peritonitis produced by the cauterization of the mucous membrane of a Meckel's diverticulum, or even of a portion of gut evaginated through this diverticulum. More often Meckel's diverticulum may be attached to the mesentery, the parietal peritoneum, the small or large intestine, the pelvis—in fact, to any organ in the abdominal cavity and even in the hernial sac.

The mortality in operations for ileus caused by Meckel's diverticulum is as high as 70 to 80 per cent. Chiefly males in the prime of life, between the ages of 15 and 35 years, are subjects of strangulation by Meckel's diverticulum.

As to the alterations caused in the abdomen by Meckel's diverticulum, the author quotes Ketteler, who collected all cases up to 1900, and found: Strangulation, 52 times; bending, 12 times; volvulus, 6 times; knot formation, 7 times; abscess in the diverticulum, 5 times; diverticulum in the hernia, 6 times; pocket formation of the diverticulum, twice; and communication with the bladder, once. In operations on Meckel's diverticulum, the stump at the point of attachment to the bowel must be treated in the same manner as the stump of the appendix, and when it is larger must be sutured with Czerney-Lembert sutures. The author further quotes Roser, that there die in Germany every year 4000 people from ileus caused by intra-abdominal strangulation. The statistics of Naunyn in 288 cases of ileus in which operation had been performed, show that of persons operated upon on the first or second day 75 per cent. recovered, while of those operated upon on the third day only 35 to 40 per cent. recovered.—*The New York Medical Journal*, February 1, 1902.

Gustave A. Van Lennep, M.D.

PHRENIC NERVE INJURIES.—Schroeder (Chicago) reports a case where he deliberately divided the phrenic nerve on the left side during an operation for the removal of a tumor from the neck. The small branch from the fifth cervical ruptured first, then the main branch from the fourth. No material change was noticed in the patient, excepting an increase in the number of respirations to 32. The divided ends were subsequently sutured with fine silk. There was no pain or respiratory embarrassment, the number of respirations being from 24 to 30 for four or five days. There was no cough, no singultus, no sneezing, none of the symptoms reported in other cases. About eight hours after the operation, percussion showed that the left half of the

diaphragm was two and one half inches above its normal position. An area of the lower portion of the lung, an inch and a half in width, showed relative dullness. Litten's sign was absent. Three weeks after, the diaphragm still remained displaced.

The author has systematically pinched the phrenic nerve in all recent operations for tubercular glands below the lower root, and noted the following results: Each time the corresponding side of the diaphragm contracted, producing a sudden and decided abdominal rising immediately below the costal arch. This has been done in 18 cases, 10 right and 8 left. In 2 cases, 1 right and 1 left, there was some pain in the region of the corresponding half of the diaphragm, which subsided in each instance before the end of forty-eight hours. The symptoms commonly ascribed to irritation of the phrenic—sneezing, coughing and hiccupping—were not observed in a single instance. A series of experiments upon dogs resulted in the following summary:

1. From the clinical and experimental data it would seem that the diaphragm is not an essential muscle of respiration.
2. That as the symptoms commonly described as caused by an irritation on the phrenic were uniformly absent, not only in the operation, but in all experimental work as well, it is safe to infer that they may have been due to something other than a simple injury to the phrenic.
3. That while, from an anatomical point of view, the diaphragm undoubtedly is innervated by branches from the intercostal nerves, this nerve supply is secondary to the phrenic, and is insufficient to carry on the action of the diaphragm after a division of the phrenic.
4. That a division of the phrenic nerve, producing a partial collapse of the lower lobe of the lung on the affected side, and an atrophy of one-half of the diaphragm, might predispose to infection of the lung or be followed by a diaphragmatic hernia.

5. That a division of one phrenic nerve in man, resulting in paralysis of one-half of the diaphragm only, is not necessarily fatal.

An instructive and interesting brochure on the innervation of the diaphragm by Green (Chicago) is added, also an extensive review of the literature bearing upon phrenic nerve injuries.—*The American Journal of the Medical Sciences*, February, 1902.

Gustave A. Van Lennep, M.D.

ACUTE CHOLECYSTITIS WITH GANGRENE.—Donoghue (Mass.) performed cholecystectomy for acute cholecystitis with beginning gangrene, as follows: The incision was through the outer border of the rectus muscle, and opened directly onto the gall-bladder, which was tense, distended and apparently full of calculi. Its surface was smooth, except for some fibrin upon the inner end, and there were no adhesions. At the outer end there was a very thin and necrotic spot. The hepatic and common ducts were free. The gall-bladder was freed from its "liver bed," the duct below the obstruction (cystic duct) was clamped, a strong silk ligature was tied, and the gall-bladder cut between the clamp and ligature and removed. Two gauze drains were passed down to the stump and the incision closed by interrupted catgut sutures, except at upper angle, out of which the gauze drain and end of silk ligature were brought. Skin closed by interrupted silkworm-gut sutures. The subsequent history was uneventful. The ligature came away on the sixteenth

day, and the wound closed throughout on the twenty-third day. The patient was a woman, fifty years of age, and the attack had lasted three days. The gall-bladder was found filled with muco-purulent secretion and a large number of calculi. The mucous membrane was deeply ulcerated in places, as if from pressure.—*The American Journal of the Medical Sciences*, February, 1902.

Gustave A. Van Lennep, M.D.

THE MANAGEMENT OF FRACTURES OF THE UPPER THIRD OF THE FEMUR.—Hibbs (New York) uses the long traction hip splint in the treatment of fractures of the femur in the upper third in preference to Buck's extension apparatus, for the reason that by its use extension can be applied that is direct and constant, always in the same line, and to a degree that will absolutely control muscular spasm. Moreover, he has found that Buck's extension apparatus loses its efficiency when the limb is flexed at 135° , as it should be in the case of the fracture under discussion. An anæsthetic should always be administered, and the splint applied as is done in the case of hip-joint disease, with the adhesive plaster extending to the point of fracture. The counter-pressure upon the perineum by the perineal straps is borne usually with comfort. These straps should be removed daily, one at a time, and the parts bathed and powdered, which will prevent any excoriation. The limb is placed upon an inclined plane, extending from the buttocks to the foot, and slightly abducted. Securing such control of the pelvis without limiting the mobility of the lumbar spine allows the patient such freedom of movement that he may sit up at any time without disturbing in the least the efficiency of the apparatus or the point of fracture. Short coaptation splints may be used in addition, to further support the bone and steady the fracture. The author reports one case treated by this apparatus in which union took place *without shortening or deformity*.—*New York Medical Journal*, February 1, 1902.

Gustave A. Van Lennep, M.D.

ECLAMPSIA AND CÆSARIAN SECTION.—(Davis.)—The first thing of paramount importance in the treatment of eclampsia is not to empty the uterus as soon as possible, but to control the convulsions and stimulate the excretory processes. When this has been begun, if the patient still shows any tendency to improvement, if the abdomen is tense and the cervix hard and undilated, Cæsarian section must be considered. Its success or failure will depend on the degree to which the patient has been poisoned by the toxines within her body. In some cases the patient is beyond hope when first seen; in others, even desperate, recovery follows.

There is especial danger from hæmorrhage in Cæsarian section for eclampsia. This tendency to bleed is seen in all highly toxæmic patients.—*American Journal of Obstetrics*, February, 1902.

George R. Southwick, M.D.

THE MORTALITY OF FORCEPS AND VERSION IN CONTRACTED PELVIS.—(Davis.)—The mortality of forceps and version under the conditions of modern practice is given by Dobbin, based upon the study of the first 1000 patients delivered in the obstetrical department of the Johns Hopkins Hospital. In cases in which the diagonal conjugate measures 10 cm. the patient is prepared for Cæsarian section. She is anæsthetized, placed upon the operating table, and axis traction forceps carefully applied over the sides of the head. But

few well-applied tractions in the axis of the pelvis are made, and should these fail, immediately Cæsarian section should be performed. The foetal mortality in his cases delivered by forceps in deformed pelvis was 9.52 per cent. The foetal mortality after version was 26.66 per cent. He had no maternal mortality in uninfected cases from either forceps or version. In one case, the degree of pelvic narrowing was considerably greater than that given by Dobbin, in which he felt justified in preparing his patient for section, and in making tentative use only of the forceps.

The results of version in contracted pelvis are given by Wolff. His collective mortality in aseptic cases for the mother was 0.5 per cent., while among the children 12.45 per cent. perished as the result of delivery. His cases were carefully selected, and only in the lesser grades of pelvic deformity was version permitted. Cæsarian section also shows to good advantage in comparison with symphyseotomy. In one hundred of the latter, twelve women and thirteen children died.—*American Journal of Obstetrics*, Feb., 1902.

George R. Southwick, M.D.

DRAINAGE AFTER LAPAROTOMY.—(Burckhard.)—Drainage should be used (1) if the field of operation and the peritoneal cavity have been soiled with a considerable amount of pus; (2) if a large cavity remains with degenerated and infiltrated walls, which cannot be brought together by suture; (3) if a portion of the tumor wall is so firmly adherent it cannot be removed, and especially if it is adherent to the intestine; (4) if there are injuries to the bladder or intestine, even though carefully sutured over; and (5) if there are pus sacks which cannot be removed, and which must be treated by incision. Drainage with sterile rather than iodoform gauze is best suited to the second and fifth classes of cases, but for the others the glass drain is preferable.

The microscopic and occasionally the culture test from an exploratory puncture, after opening the pus sac at the time of operation, are uncertain, and often give unsatisfactory results.—*Zeitschrift für Geburtshilfe und Gynäkologie*, Bd. 46, H. 2, p. 258, 1901.

George R. Southwick, M.D.

THE THERAPEUTICS OF REPEATED ABORTIONS AND STILLBORN CHILDREN, WITH PREMATURE LABOR.—(Lomer.)—In many cases, inspection of the product of conception suggests the cause of abortion. Hæmorrhage on the lower pole of attachment means placenta prævia. Criminal abortion is indicated by the presence of fever and a putrid discharge, or the discharge of a foetus in a fresh condition, with retention of the placenta. The writer urges the importance of thorough treatment throughout pregnancy, in case of repeated abortions, with iodide of potash and Bland's pills. It has a specific action on an old or inherited syphilis. It has a favorable effect on the hyperæmic kidney of pregnancy. It has an absorbent effect on endometritic processes. All three effects may aid to cure the patient, and the writer believes that the iodide of potash does much to prevent the rupture of blood-vessels in the placenta. Chronic anæmia is often present in these cases, and on this account special importance is attached to the persistent use of iron at the same time.—*Zeitschrift für Geburtshilfe und Gynäkologie*, No. 46, H. 2, 1901.

George R. Southwick, M.D.

THE NATURE OF NEUROPARALYTIC KERATITIS.—The author goes over the various theories on this much-discussed subject, and comes to the follow-

ing conclusions : The keratitis which we see in human beings after paralysis of the fifth, in some cases, is undoubtedly caused by the desiccation of the cornea. It is usually caused by trophic disturbances, resulting from a lesion of trophic fibres, which are found on the inner side of the fifth, and which many observers claim arise from the sympathetic.

In support of this view, the following case is reported :

A woman of thirty years was affected with complete anæsthesia in the region of the branches of the right fifth nerve. The right side of the face, of the mouth and the tongue were absolutely insensitive to irritating influences. The movements of these parts were normal. There was slight ptosis, and the eyeball lay somewhat in the orbit. The intraocular tension was diminished. The movement of the orbicularis was normal. There was absence of the corneal epithelium, except of a small peripheral portion of an area of 3 mm. The parenchyma was the seat of a thick clouding. The tear secretion was lessened, but the eye was apparently well moistened. Vision was considerably reduced. The case belonged to that variety of neuroparalytic keratitis where the peculiarity lay in the fact that trouble had never gone on to sloughing of the cornea. It is interesting to note the fact that neither a trauma nor desiccation alone could be blamed for the keratitis. The eye was well moistened, and the ptosis protected it from trauma and desiccation. We are justified, then, in concluding that the keratitis was due to trophic disturbances, caused by paralysis of the fifth pair.—J. Bastis, M.D., Constantinople, *Central. fur Prakt. Augen.*

William Spencer, M.D.

THE MYDRIATIC ACTION OF PILOCARPINE SOLUTIONS.—The peculiarity of many of the pilocarpine preparations which are now on the market of producing more or less mydriasis has attracted the attention of Lilienfeld. He reports a case in which pilocarpine was employed, and a mydriatic effect was produced. This effect has, of course, been long known, and pharmacologists have endeavored to get a preparation which is absolutely free from this property. His communication comprises a number of clinical and physiological experiments, and his conclusions are practically as follows : He does not think that we can dispense with this agent, for, as yet, we have no satisfactory substitute, though it must be said that the article which we get from drug stores is generally, to some extent, untrustworthy, and will doubtless remain so till it has been tested physiologically and chemically, and in this way shown to be pure. Before it is used for therapeutic purposes it should be tried on the healthy eye to see whether it acts properly, and if so, we can employ the article in our glaucoma cases with confidence.

Inasmuch as changes take place in pilocarpine solutions after standing a long time, he advises that only small quantities be put up, and that, after two or three weeks, the solution be renewed.—Ernest Lilienfeld, M.D., *Central. fur Prakt. Augen.*

William Spencer, M.D.

CHALAZION.—After giving a *résumé* of our present knowledge of chalazion, the writer says : Thus we see that the condition with which we deal is not simply a retention cyst, but a true inflammatory product, with the associated but incidental accumulation of fluid, some of which is true glandular secretion, the rest indefinite product of the unhealthy cyst wall, and suggests the following as a definition : “ Chalazion is a tumor in the lid, involving the

Meibomian gland, with obliteration of the glandular elements; it is limited by a surrounding membrane, within which are found the perverted secretion of the earlier gland, glandular debris, micro-organisms, and sometimes pus."

The writer believes that the general health has considerable influence in causing this condition, and that some disorder may produce a thickened secretion, whereupon the constant rubbing to which the lid is exposed, aided, perhaps, by incidental germ infection, starts the inflammation which leads to chalazion. Concerning treatment, he states that in young children, and sometimes in adults, where the tumor has appeared suddenly, and is not hard or thoroughly circumscribed, absorption may take place either spontaneously or by the help of heat and gentle massage. When the tumor has irritated or eroded the conjunctiva, and either softened or broken through this underlying tissue, it should be excised through the conjunctiva, followed by the eurette. Where the conjunctiva and its adjacent tarsus are unaffected, but where the overlying tarsal wall is thinned and the direction of least resistance thus made evident, the tumor should be excised through the skin. The incision can be made parallel with the free border of the lid, the orbicularis carefully pushed aside, and the tumor, with its wall, dissected from the tarsus; the skin incision is then closed by one or two stitches. Under such circumstances, excision through the skin is cleaner, more scientific, and no more painful than when removed through the conjunctiva; the tumor never returns, and no scar need result.—Albert B. Hale, Chicago, *Ophthalmic Record*.

William Spencer, M.D.

DANGER FROM ADRENALIN IN THE EYE.—Its astringent contraction extends to those branches of the long ciliary arteries which anastomose with the conjunctival vessels and supply the more superficial portions of the sclera anteriorly.

The tendency, then, of its local application is to blanch the conjunctiva at the expense of risking the engorging of the deeper anastomosing blood-supply of the iris and ciliary body. With these vessels in their normal condition, and the iris or cornea unaffected, this danger is practically *nil*. But with a tendency to iritis, and especially such tendency as accompanies keratitis and corneal ulcer, the danger is very real. A superficial corneal ulcer was, after the instillation of adrenalin chloride solution 1 to 1000, complicated with adhesive iritis. Two cases of iritis were progressing favorably when acute exacerbations, together with adhesions, immediately followed the use of this drug.—Henry B. Lemere, *Amer. Med.*

William Spencer, M.D.

VALVULAR HEART DISEASE IN RELATION TO PREGNANCY AND LABOR.—(Webster.)—Notwithstanding the very serious nature of heart disease complicating pregnancy, very little attention has been given the subject in text-books. As is well known, many of these cases pass through labor safely, and with little or no disturbance. The question arises, when a patient suffering from a chronic valvular disease becomes pregnant, "What is likely to be her course?" When we take into consideration the changes which take place in the maternal blood, therefore in the circulation, it is not to be wondered at that basal systolic murmurs develop in the greater percentage of cases. These are probably due to the altered condition of the blood, but cardiac dilatation may also be a factor in their production. The increased work demanded

of the heart is met by hypertrophy, mainly of the left ventricle. It is also probable that with hypertrophy there is more or less of dilatation.

Another question arises: "Is there an endocarditis of pregnancy?" When we look at the conditions present which favor valvular changes, as hypertrophy, dilatation, altered blood-pressure, increase in the fibrin elements of the blood, it is, to the minds of some writers, fair to presume that there may arise a true endocarditis of pregnancy. The greatest majority of cases are those of chronic valvular heart disease which had existed before the pregnancy. The gravest cases are those which occur before compensation has been well established.

Of greatest importance are disturbed metabolism and imperfect metabolism, whereby toxic materials circulate and directly poison the cardiac muscle.

Very few women go to the full time without the appearance of some unfavorable symptoms, such as dyspnoea, palpitation, oedema.

Treatment.—Such drugs as digitalis, strophanthus, glonoin are indicated when there are signs of heart failure.

Perhaps the most conservative statement as to the emptying of the uterus is, "If the mother be in a good state, an effort should be made to carry on the gestation." If the patient show signs of heart failure, the indication is to empty the uterus at once.—*Medicine*, February, 1902.

William F. Baker, A.M., M.D.

THE THERAPEUTIC VALUE OF ADRENALIN.—(J. J. Kyle).—Much has been written concerning the use of the suprarenal in watery solutions, but these are unstable; hence its use is advised in the form of an unguent. Because of its instability, the active principle was sought, and we have given us adrenalin. This is a fine crystalline powder, slightly alkaline and slightly soluble in water. The crystalline powder is used dissolved in normal salt solution (1 to 1000) with 0.5 per cent. chlorotone. This solution may be applied to the mucous membrane of the nose, throat or eye. The ischemic effect is immediate, and usually lasts fifteen minutes to one hour. The weakest solution probably in use is 1 to 10,000, which, when dropped into the eye, at once produces a blanched appearance of the membrane and relaxation of the turgescence. For all general uses the strength should be 1 to 1000.

There is no perceptible brain effect following the use of this drug; therefore it can be continued. Neither is there any local irritation resulting. As a spray in acute coryza and acute laryngitis, it is of special use. Its usefulness as a collyrium in painful serous iritis, as an adjunct to atropine or cocaine, is a matter of further investigation; so far its value has been well demonstrated.

For the extraction of foreign bodies from the larynx, the pharynx should be well sprayed, followed by a spray of fifteen per cent. solution of cocaine. Many reports are current showing the advantage of the administration internally of the powdered suprarenal gland in hay-fever, Addison's disease, and especially in diabetes insipidus and neurasthenia.

It is reasonable to presume that, as with such drugs as opium, coca, coffea, the active principle of the gland will be the agent most relied on.—*Therapeutic Gazette*, Jan. 15, 1902.

William F. Baker, A.M., M.D.

CULTURE PRODUCT IN THE TREATMENT OF TUBERCULOSIS.—(Pottenger.)—After a careful review of the literature on the subject, and after personal investigations, the writer comes to the following conclusions:

- (a) Culture products do have a specific action on the tuberculous foci.
 - (b) That this has not been recognized has been due to the early unfortunate experience with tuberculin, because it was used in too large and too frequent doses. It was also employed in unsuitable cases, and it was held responsible for all post-mortem findings.
 - (c) The field of usefulness for culture products is where recent tubercles are found, and this especially in incipient cases.
 - (d) If used in advanced cases, culture products will help remove areas of recent extension, but must not be expected to remove dead or decaying or newly-formed tissue.
 - (e) Where culture products are used, they should be reinforced by every means at command. Every phase of the patient's health should be looked after, and the best hygienic and dietetic measures be advised.
 - (f) Where the case is managed and the culture products are used, the proportion of cures is greater than when they are not used.
 - (g) Culture products produce an immunity which protects the patient from a relapse, hence make a permanent cure more often than hygienic or climatic treatment alone. This fact alone should justify their use in all suitable cases.
- Therapeutic Gazette*, Jan. 15, 1902.

William F. Baker, A.M., M.D.

THE PATHOLOGY OF DIABETES.—(Flexner.)—Although the pancreas has been shown to influence and regulate carbo-hydrate metabolism, it is by no means proven that the cause of diabetes is always resident within that organ. The complete removal of the pancreas in animals is always followed by a diabetes of severe type, yet it can be removed in part, and not necessarily be followed with diabetic symptoms. The amount of the gland left behind should be at least one-fifth. It was also learned that the diabetes resulting from the extirpation of the pancreas is fatal. Of the causes of the pathological changes in the pancreas, the chief one is supplied by concretions in the ducts.

That diabetes can result from disease of the liver seems probable, as that condition has been observed following traumatism, as an accompaniment of cirrhosis and congestion.

Pathological conditions of the central nervous system and the peripheral nerves may cause diabetes and glycosuria. What the relation of the central nervous system and the organs of the carbo-hydrate metabolism is we are not informed. Naunyn states: "I hold it as proven that diseases of the nervous system lead to diabetes, in that there occurs coincidently disturbances of function in other organs which preside over the carbo-hydrate metabolism; that these disturbances are not simple expressions of the abnormal functional activity of the central organs; but, using the analogy of the motor in contradistinction to the nutritive or secretory neuron, we can imagine that each stands for an entity, the one acting on the muscle cell (motor neuron) and the other upon secretory cells, as in the liver and pancreas (secretory or nutritive neuron). And just as diseases of the motor neuron in any part set up pathological changes in the entire system, so may the secretory organic cells be

influenced injuriously in such ways as to give rise to diabetes, because of their connection with diseased nervous structures with which they indissolubly unite, and under whose domination they are." The existence of the renal form of diabetes is yet unproven.—*University of Penna. Medical Bulletin*, Jan., 1902.

William F. Baker, A.M., M.D.

THE TREATMENT OF HIGH BLOOD-PRESSURE IN RENAL DISEASE.—Carter reaches the following conclusions:

(a) When the blood-pressure is high, as in chronic nephritis, and is accompanied by symptoms of uræmia, the best treatment is venesection to the extent of withdrawing 5 to 8 ounces of blood, followed by the infusion of 1400 to 1500 cm. of hot normal saline solution.

(b) Sodium nitrite in full doses (3 grs. every four or five hours) should be given in combination with the above.

(c) The combined treatment as above indicated is almost invariably marked by improvement.

(d) The average mean blood-pressure in chronic nephritis is 62 mm. of mercury higher than that of acute nephritis.

(e) The blood-pressure in acute nephritis is about the same as in health; and when the pressure rises to the extent of 60 mm. higher than health, the presence of chronic nephritis, or other cause of increased blood-pressure, may be suspected.

(f) Symptoms of arterio-sclerosis are often clinically combined with high blood-pressure, and the combined treatment (venesection, saline infusion and administration of nitrites) is thus also indicated as specially valuable in averting threatened cerebral hæmorrhage, which is a common sequel in arterio-sclerosis.—*Am. Jour. of the Med. Sciences*, Dec., 1901.

F. Mortimer Lawrence, M.D.

THE LEUCOCYTES IN YELLOW FEVER.—Gray, of St. Lucia, has been able to confirm the observations of Christophers and Stephens as to the increase in the number of large mononucleated leucocytes in malarial fever, and suggests that if a similar increase does not take place in yellow fever, we possess a valuable means of differential diagnosis in doubtful cases. The latter appears to be indicated by his investigation of three cases of yellow fever, in which the percentage of large mononucleated leucocytes was 11, 8.33 and 7.66 respectively, while in his malarial cases the lowest percentage was 19.—*Brit. Med. Journal*, Jan. 25, 1902.

F. Mortimer Lawrence, M.D.

THE CLASSIFICATION OF THE VARIETIES OF ANGINA PECTORIS.—Gibson, in the first of the Morison Lectures at the Royal College of Physicians, of Edinburgh, devoted the concluding part of his address to a classification of the different varieties of angina pectoris. He considered that the current classification into true and false angina pectoris was devoid of any scientific basis, but that cases of the affection naturally fell into two divisions, organic and inorganic. To the former division belonged all varieties depending upon obvious changes in the heart and great vessels within the chest, while under the latter fell several distinct types, in which there were no definite structural alterations—for example, the toxic, including the effects of such chemical substances as alcohol, tea, tobacco and uric acid, and such microbic influences

as may be seen in influenza, malaria and typhoid fever, and the neurotic, embracing the effects of reflex irritation, of spasm of the arteries, of nervous debility, and of hysteria.—*Brit. Med. Journal*, Jan. 25, 1902.

F. Mortimer Lawrence, M.D.

THE SURGICAL TREATMENT OF OBSTRUCTIVE JAUNDICE. — Before the Medical Society of London, Mr. A. W. Mayo Robson read a paper entitled "Observations on the Surgical Treatment of Obstructive Jaundice, Resulting from an Experience of over 200 Operations." He said that his recent operative experience in cases of chronic obstructive jaundice, especially in those associated with gallstones and with chronic pancreatitis, had led him to take a more hopeful attitude in considering the treatment of deeply jaundiced patients from a surgical standpoint. The first and often most difficult question was that of diagnosis, and the following causes of jaundice must be taken into consideration: (1) common duct cholelithiasis; (2) chronic pancreatitis; (3) simple stricture of the common bile duct; (4) inflammatory adhesions causing pressure on, or stenosis of, the hepatic duct or of the common bile duct; (5) hydatid disease of the liver pressing on or discharging into the bile ducts; (6) gummata implicating the ducts; (7) chronic catarrh of the bile ducts; (8) cancer of the common bile duct; (9) cancer of the head of the pancreas; (10) cancer of the liver, associated with jaundice, due either to catarrh or pressure; (11) cirrhosis of the liver; and (12) other rare causes, such as aneurism of the hepatic artery or of the aorta, and other tumors of the liver, gall-bladder, the pylorus, the kidneys, or the intestines, pressing on or occluding the common bile duct. Medical treatment alone is advisable for the sixth and seventh causes; in the remainder, with certain exceptions, relief can only be hoped for.

A painless onset of chronic jaundice must always give rise to a suspicion of either chronic catarrh dependent on cancer of the liver, or of occlusion of the hepatic or common bile duct by a growth; and if this be associated with distention of the gall-bladder and rapid loss of weight and strength, cancer of the head of the pancreas would probably be found. On the other hand, history of an attack of pain followed within 24 to 36 hours by jaundice is strongly suggestive of cholelithiasis. Enlargement of the liver is much more common in obstruction due to cancer than in that from gallstones. The presence of ascites is suggestive of malignant disease. The jaundice of gallstones is rarely continuous, increasing and diminishing from time to time, whereas the jaundice of obstruction due to a growth increases steadily. Fat in the stools and glycosuria with rapid wasting are suggestive of pancreatic trouble. A rigid right rectus abdominis and tenderness one inch above and to the right of the umbilicus are suggestive of gallstone trouble.

Treatment depends on diagnosis:

1. If the diagnosis is doubtful, an exploratory operation is advisable, provided the general condition of the patient renders it probable that such a procedure, *per se*, will not hasten death.

2. If malignant disease is positively diagnosed, operation can, with some few exceptions where it has been possible to completely remove it, do but little good.

3. If gallstones, or in fact any of the first five enumerated causes, are diagnosed, operation is decidedly advisable.—*The Lancet*, Jan. 18, 1902.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF DYSENTERY BY RECTAL INJECTIONS.—Lillie has tried the injection method in a number of cases of dysentery in South Africa, and found it most useful. He used an apparatus composed of a soft œsophageal catheter, attached by a piece of glass tubing to some soft rubber tubing about three feet in length; to this was affixed a large glass funnel. The patient was placed on his left side, and the hips drawn over to the edge of the bed. The knees being flexed, the end of the catheter, smeared with vaseline, was introduced into the rectum with the greatest care, the patient being directed to strain meanwhile. Cocaine was used for the anus if required. The catheter was introduced about four inches without using any force. The patient then being placed gently on his face, the hips well raised on pillows, and the head and shoulders placed low, the warm lotion—usually boric acid, 10 grs. to 1 ounce—was introduced without any difficulty into the bowel. The apparatus was previously filled with lotion, and a clamp applied, so as to avoid injecting air into the bowels. By raising or lowering the funnel the rate of injecting the solution was readily regulated. Small quantities only were allowed to run in slowly at a time—an ounce or so every few seconds. He generally used these injections two or three times a day, and the bulk of the enema was never less than a pint and a half.—*Brit. Med. Journal*, Jan. 25, 1902.

F. Mortimer Lawrence, M.D.

THE RELATION OF THE NOSE TO THE FEMALE GENITALIA. NASAL REFLEXES.—(Heymann.)—The nose is especially a reflex organ. The irritation exciting the reflex affects mostly the trigeminus, or the olfactorius may pass over these nerves from near or more remote centrifugal paths. There are reflexes, however, in which the nose is the end organ, in which a near or more remote irritant causes a swelling or shrinking of the nasal mucous membrane, and especially of the turbinated bodies. There are three groups of nasal reflexes :

1. Those where the irritant and reflex act in the nose.
2. Those where an irritant in the nose excites a reflex in a distant organ.
3. Those where an irritant in a distant organ excites a reflex in the nose.

The relation of the nose to the female genitalia includes the two last groups. Epistaxis after sexual excesses has been long known. Observations of vicarious epistaxis have been made repeatedly. The increased congestion of the nasal mucous membrane during menstruation affects especially the tuberculum septi and the anterior end of the lower muscle, which have been termed by Fliess the genital areas of the nose. These latter are important in dysmenorrhœa. Cocainization of these areas or thorough cauterization have given temporary and, in some cases, permanent relief. Treatment of the lower muscle affects the pains in the hypochondrium, and of the tuberculum septi the pain in the sacrum; sometimes the effect is crossed, but usually on the same side. The application of cocain enables the physician to determine whether the case is one of nasal or mechanical dysmenorrhœa. In nasal dysmenorrhœa, Fliess differentiates the dysmenorrhœa of development and acquired dysmenorrhœa, the latter being associated with suppuration due to some infectious disease. Successful treatment followed the cure of the suppurative process. Fliess has also treated dysmenorrhœa, with irregular menstruation, menorrhagia, and one case of amenorrhœa. Eminent German authorities are of the opinion that the cases cured were cases of hysteria,

and that the cure was by suggestion.—*Centralblatt für Gynäkologie*, No. 48, 1901.

George R. Southwick, M.D.

FEVER DURING THE PUERPERIUM.—(Moran.)—One of the most common causes of fever, aside from the infection of the genitalia, finds its source in the intestines. Following labor, there is usually a semi-paresis of the intestinal tract, favoring fermentation and decomposition therein, and the fever subsides readily after free catharsis.

Since we do not use douches as a routine measure, and as the morbidity is double that of cases examined over those not examined, many of the cases of sapræmia and pathogenic infection, except gonorrhœa, must be due to contamination by the hand of the attendants, or by direct transference of the infection from the vulva. It would seem, then, that morbidity might be lessened greatly by observing the following pointers :

1. Careful observance of aseptic technique on the part of the physician and nurse, at all times regarding the parturient tract as a surgical wound.

2. Restricting or avoiding internal examinations and cultivating external diagnosis. Where internal examinations are made, care should be exercised to separate the labia, so that the examining finger will avoid contact, so far as possible, with the vulva.

3. A thorough knowledge of the mechanism and conduct of labor, with due appreciation of timely interference.

4. Refraining from haste or violence in expulsion of the placenta.

5. Avoiding early rupture of the membranes.

Every case of fever during the puerperium should be regarded as septic until positively excluded by a most careful and painstaking examination.

The immediate history will give the character and duration of the labor, the quantity and character of the lochia, and should also ascertain whether the patient has suffered prior to labor from phthisis, malaria or typhoid. You can also exclude, by the accompanying symptoms, influenza, pneumonia, hysteria, exanthemata, diphtheria, and other diseases. If the indications point to involvement of the genital tract, a thorough bimanual and specular examination should be made, and, if possible, supplemented by a bacteriological and microscopical examination.—*American Journal of Obstetrics*, February, 1902.

George R. Southwick, M.D.

SHORTENING THE ROUND LIGAMENT THROUGH THE VAGINA.—(Bucura.)—The technique may be outlined as follows : The plica vesico-uterina is opened after the anterior vaginal wall of the uterus and its edges are fastened temporarily to the vagina. The uterus is gradually hooked up and pulled forward into the wound by climbing up on the anterior wall with fine tenacula until the retroversion is converted into an antelexion and the fundus is visible. The round ligaments are then readily recognized and hooked down in the wound, the tubes and ovaries are examined by touch and sight, any adhesions are separated, and such other operations performed as may be necessary. The loops of round ligaments are sutured together with fine silk, thus shortening them, and then returned to the abdomen. The plica and vaginal incisions are then closed. The patient remains in bed ten days ; no pessary is used. She is instructed to urinate once in three hours, and not to lie on her back.

This operation has been performed on 86 women in Wertheim's clinic, in Vienna. There has been recurrence of retroversion in 2 cases, both of which

were complicated. Seven women have had perfectly normal labors; 1 of them has been in labor twice, and in 6 the uterus has remained in position.

In 459 and 593 cases, respectively, of ventral fixation and vaginal fixation collected from literature, there were permanent results in 94.77 per cent. in the former and 91.9 per cent. in the latter, but both methods have disadvantages. There were 27 cases of hernia in 289 cases of ventral fixation, or about 9 per cent. The complications in labor following vaginal fixation are too well known to quote. The advantages of vaginal shortening of the round ligaments as compared to Alexander's method are less danger of hernia and avoiding a scar. Plastic operations are often necessary at the same time. Vaginal shortening can be performed whenever Alexander's operation is indicated, but the reverse is not true, as adhesions and diseases of the tubes and ovaries do not contra-indicate this method of operating. The permanent results are about the same. Three hundred and eighteen cases of Alexander's operation collected from literature show 15.1 per cent. of recurrences.—*Zeitschrift für Geburtshilfe und Gynäkologie*, Bd. 46, H. 2. 1901.

George R. Southwick, M.D.

A CASE OF PURPURA FULMINANS. —Dr. Borgen describes a case of that disease which Henoch, of Berlin, first called to our attention, and named purpura fulminans. It is a variety of purpura which is rapidly fatal, and is characterized by an absence of hæmorrhages from the mucous membranes. These cases are very rare. The patient in question was a child of two years, a boy, who, eight days before the appearance of the purpura, was noticed to have an enlarged cervical gland. The disease began by the appearance of cyanotic patches upon the right thigh and the left leg. At the same time the child was somewhat excited, though its general condition was quite satisfactory. The next two days the purpuric spots increased in number, so that they covered the outer and inner sides of the thighs, the front and sides of the legs, the forehead and the left forearm. These blotches, firm to the touch, presented a few small areas of the size of a hemp-seed where the skin was normal. The child had become extremely pale, its lower limbs œdematous, the temperature being only 36.5°. On the evening of the third day it vomited a little blood; death took place during the night. The necropsy revealed only a slight hypertrophy of the lymph-glands of the neck, the mesentery, and of the groin, with a general paleness of the organs and skin. The cervical glands only offered a few hæmorrhagic areas on section. Cultures made from the glands, spleen and blood demonstrated the presence of a streptococcus; these were also detected on the pharyngeal mucous membrane and in the lymph-glands of the neck. Sections from the liver, spleen and neck revealed none.—*La Semaine Médicale*, No. 52, 1901. (Many of these cases are septic in origin, the point of entrance of the micro-organisms being often difficult of detection. In such cases it seems as if the infectious process, instead of causing a local suppurative state, brings about a general infection. It might be well, in such cases, to prescribe such remedies as produce a septic blood-dyscrasia, or to try Crede's collargol. There is still another class of similar maladies, at least those with analogous clinical symptoms, where a scurvy-like diathesis is at bottom. Here Prof. Jacobi, of New York, claims good results from phosphoric-acid compounds. He "lumps" scurvy, Barlow's disease, and similar states into one group, and treats them accordingly.)

Frank H. Pritchard, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

CONDUCTED BY O. S. HAINES, M.D.,

with the collaboration in German literature of C. Sigmund Raue, M.D.

HYDRASTIS CANADENSIS AND ITS ALKALOIDS.—At a recent meeting of the A. R. Thomas Club, conversation drifted upon the therapeutic uses of the hydrastis and its two alkaloids. Dr. E. W. Mercer said that he had been gratified with the prompt and lasting effects of hydrastinine hydrochlorate in uterine hæmorrhages, and in hæmorrhages depending upon malignant growths in the uterus. He had found that this remedy controlled the bleeding, even although the growth goes on. He uses the second decimal trituration.

Dr. P. H. Ealer had long used the hydrastin sulphate 2x in stubborn cases of constipation; those cases in which no evacuation occurs for days at a time, unless a laxative be taken.

Dr. Shallcross stated that he had made extensive experiments with the hydrastis for the purpose of establishing its place in the therapeutics of chronic naso-pharyngeal affections, and had thus far come to the following conclusions: The remedy, hydrastis, acts best for him in the first decimal dilution from the mother tincture. It seems to be particularly useful in hypertrophic or pseudo-hypertrophic rhinitis with follicular pharyngitis. While it may occasionally help in atrophic pharyngitis, it cannot be said to be generally useful. Dr. Shallcross thought that the internal administration of the 1x dilution had been fully as efficacious as the combined internal and local treatment. The discharges from the mucous membranes are thick, viscid and yellow. Many patients suffer from gastric symptoms and from obstinate constipation. Dr. Landreth Thompson had been pleased with the prompt effects of the local use of the remedy in chronic urethral catarrhs, and also acute catarrhal conjunctivitis. He used a solution of from two to four grains to the ounce. Dr. Carmichael related an instance of colloid cancer of the abdomen that had been operated some two years ago and sent home to die. The patient did not die, but has been taking hydrastis tincture, five drops three times daily, for the past two years. She has also taken occasionally iodide of arsenic and arseniate of strychnine in low trituration. The abdominal wound opens occasionally and discharges an amount of the colloid material, but the patient's health has not deteriorated during the past two years. The hydrastis is a vaso-constrictor, and therefore probably acts better upon such cases in appreciable dosages. We probably get its physiological effects. So Dr. Carmichael thinks.

ANTITOXIN AS A PROPHYLACTIC.—Dr. Cowperthwaite, in his late "Practice of Medicine," says that he is convinced of the great harmfulness of antitoxin, when generally and indiscriminately used as a prophylactic. He would not use it as a prophylactic in an epidemic of tonsillar diphtheria, but would use it only in the presence of a very malignant class of cases. He recommends 150 to 300 units, *according to age*, for purposes of immunization. This will be regarded as a rather small dose. The author thinks the idea that antitoxin is of no service when used late in the disease is incorrect. It was the observation of this class of cases, where antitoxin, at the last moment, proved a veritable savior, that forced him to admit the efficacy of the treatment, in spite of previous strong convictions to the contrary. We believe that recoveries from antitoxin administered late in the course of the disease are exceptional. If it is to be used in a case, the physician cannot begin too early. It has been stated that in no instance does it fail when administered within the first twenty-four hours. This is not true. Antitoxin is by no means a specific remedy, and we believe that the time will come when it will be definitely known which kind of diphtheria cases may be cured by antitoxin, and which kinds are not amenable to its curative effects. It certainly is not efficacious in all cases.

VACCINIUM AS AN IMMUNIZING AGENT.—"We employed a graduated nurse to care for one of our cases. She had been taking vaccinium powders. She came to us and wanted small-pox cases. In about two weeks the disease developed, although she had taken the powders faithfully. She nearly died. The powders did absolutely no good."—Dr. Mann, in *New England Med. Gazette*. Vaccinium powders or pills are not "just as good as vaccination!" Homœopathy will not be advanced by such methods of "substitution."

CLINICAL EXPERIENCES WITH ECHINACEA.—Dr. W. H. Nickelson has used echinacea tincture, in ten-drop doses every three hours, with marked success in septicæmia. The case he mentions in his article in the *N. A. Journal* began with a chill upon the fifth day after confinement. We think that it should be borne in mind that the septic conditions occurring after childbirth are not all cases of true septicæmia. We should also remember that in this class of cases the prognosis is far more favorable than it is under other circumstances. Indeed, the prognosis depends upon the ease and rapidity with which the putrefying materials can be removed from the interior of the uterus. For these reasons, we believe that where the treatment of such a case includes not only the administration of a remedy, but also intra-uterine injections of some antiseptic solution, the physician should be slow in claiming *all* the credit of the cure for the internal remedy. Such a claim could hardly be substantiated, and, moreover, might lead others to substitute that remedy for the combined treatment in other cases, and probably with less favorable results. It is not our intention to be hypercritical, yet it is very essential that every homœopath should feel that the basic treatment of septic conditions occurring after childbirth should always be the mechanical removal of all putrefying material from the genital canal and uterus, and the systematic use of the proper antiseptic in solution. Internal medication and everything else should be considered simply as an adjuvant measure. Dr. Nickelson, however, realizes this, because he is careful to mention that irrigation and veratrum viride produced no improvement in eighteen hours; but

that under the echinacea the temperature fell within the next succeeding twelve hours. This case was a grave one ; and from it we must conclude that the echinacea, as recommended, had a distinct effect upon the septic process. And yet, we have no indications upon which we can prescribe this remedy in septicæmia, save the single one of "sepsis." On the other hand, we have most reliable indications for the use of such old remedies as baptisia, arsenicum, carbo veg., arnica, lachesis, and croctalus. Such remedies as these and others may be selected strictly according to our law of cure. If the physician wishes to go outside of homœopathy, he may surely place more dependence upon sulphate of quinine than upon such an illy understood drug as echinacea. The quinine has stood the clinical test for a long time ; it certainly should not be overlooked in favor of an immature two-year-old like echinacea.

The eclectic profession know probably more about the echinacea than we do. They praise it highly in all conditions in which "blood-poisoning" is a prominent feature. Thus, in typhoid fever, they claim that under its continuous use the blood does not become impaired, the assimilation and nutrition are increased, elimination is improved, the enteric symptoms abate, the danger of hæmorrhage is lessened, and there is little tympanitic distention. In other words, the case treated by echinacea runs, as a rule, a mild course. Many homœopathic physicians use this remedy largely in typhoid fever, and think as well of it as our eclectic brethren. Baptisia used to be used in the same routine fashion, yet the fact is apparent to anyone who cares to see, that baptisia cases of typhoid are much less frequent than bryonia or rhus tox. cases. It is a grave error to give baptisia or arsenic to a case of fever, simply because its type is typhoid, without regard for the therapeutic requirements of each case. The same must be true of the empirical administration of echinacea in all cases that belong to the septic group. Homœopathy rescued the medical profession from the empirical quagmire of doubt, uncertainty and guess-work ; but we have not entirely overcome the tendency to go back and wallow.

THE RELATIONSHIP OF THE "PHOSPHOTHERAPIA" IN RICKETS TO HOMŒOPATHY.—Before Kassowitz established the custom of administering phosphorus as a specific in rickets, he took pains to demonstrate that, by drugging animals with this poison over an extended period of time, an inflammatory reaction in the epiphyses and at the mid-portion of the diaphysis of long bones could be induced pathologically identical with rickets (*Rachitis*, Wien, 1882). Others had also claimed to reproduce rickets in animals with phosphorus-feeding and at the same time withdrawing the lime salts from the food. Among these was Wegner, who was perhaps the first to recommend phosphorus in bone affections, owing to its marked influence upon the development of bone (*Virchow's Archiv*, 1972, quoted by H. C. Wood). In 1884 Kassowitz published his article confirming the value of phosphorus in rickets and recommending it as a specific (*Zeitschrift für Klin. Med.*). Since then it has become the generally accepted treatment by the dominant school, being indorsed by such pediatricists as Demme, Hagenbach, Soltmann, Jacobi and Holt. In our humble estimation this method of prescribing, especially when we reflect upon the course of experimentation and reasoning that was adopted to arrive at its acceptance as plausible and scientific, is one of the

best examples of the Hahnemannian method in therapeutics, and one of the strongest proofs of the efficacy of *similia similibus curentur* with which we happen to be acquainted. Baginsky (*Lehrbuch der Kinderkrankheiten*, 1899) goes his colleagues one better; he individualizes. He does not believe that phosphorus acts equally well and positively in all cases; in fact, some have succumbed or remained unimproved in spite of the remedy. Such cases, however, in which laryngeal symptoms predominated, namely, those complicated by laryngismus stridulus, seemed most appropriate. In this affection he can give phosphorus the most praise; "here it occasionally controls the attacks in a surprisingly short time, indeed, apparently before it has had an opportunity of influencing the rachitic process." But phosphorus does not cure all cases, and neither do we, as homœopaths, invariably prescribe calcarea phosphorica, but give calcarea carbonica, ferrum phosphoricum, silicea, and other remedies as they may be indicated. We may well accept Baginsky's special indication for phosphorus in rickets, which is a clinical observation of which Father Hahnemann would have been proud.

THE TREATMENT OF FACIAL NEURALGIA.—Dr. Moeser, Stuttgart (*Homœopathische Monatsblätter*, Jan., 1902), admits that any remedy which may be indicated in a case of facial neuralgia should prove curative. However, in his experience, certain remedies have proven most reliable, and he has found them more frequently indicated than others. He places special reliance in the following: Chininum arsenicosum, 2d or 3d trituration; mezereum, 1st or 2d dilution; silicea and magnesia phosphorica, 2d and 3d triturations; atropine and aconitine, 3d to 4th trituration; thuja θ and 1st dilution. Locally he has obtained excellent results from verbascum thapsus tincture.

A CASE OF CHRONIC ECZEMA CURED WITH GRAPHITES.—Dr. Oscar Hansen, of Copenhagen (*Allg. Homœopathische Zeitung*, Jan. 2, 1902), reports a case of eczema of seven years' standing in a woman 26 years old. She had been under allopathic treatment, receiving a great deal of arsenic. The eruption was universal, but at the present time mainly confined to the extremities and eyelids. There are papules which become vesicular and exude a viscid secretion. Graphites 2x trit., 2 grains three times daily, was administered. Prompt improvement followed, and a complete cure was effected after several weeks.

THE COW-POX EPIDEMIC.—If one may judge the temper of the English homœopaths by the editorial of the *Homœopathic World* for February, our brethern across the sea are not relishing the enforced vaccination, notification and isolation as carried on by the medical "Establishment" in London. The editor thinks that it says little for the initiative and enterprise of the homœopathic body in that country that the advocates of blood-poisoning with cow-pox should hold undisputed sway in the councils of the nation. In his opinion, cow-pox is not an acute disease which is all over when the scabs of the pocks fall off, but a chronic malady. This is recognized by the opponents of vaccination, when the acuter phases are followed by inveterate skin affections, by neuralgias, dyspepsias, new growths, or other manifestations of the dyscrasia. We do not always recognize the connection of such manifestations with the acute phases of cow-pox. We homœopaths in America, as a class, are rather favorable to vaccination, and believe it has a positive protec-

tive power in relation to small-pox. We think this has been conclusively established in our present epidemic. Yet the more thoughtful will, we think, admit that occasionally evil results follow vaccination; and, as the editor of the *World* remarks, perhaps those physicians who recognize the relationship between the cause and effects can cure such cases; while those who do not can only palliate, if they can do that. We feel that the homœopathic treatment of small-pox would, if universally carried out, rob small-pox of many of its terrors, and the editor thinks, moreover, that the mania for universal cow-poxing would then die a natural death.—*The Hom. World*.

THE VALUE OF HYPERICUM IN A CASE OF PARALYSIS AGITANS, COMPLICATED BY SPINAL TRAUMATISM.—Dr. Giles F. Goldsbrough is a master in the art of reporting clinical cases. He mentions, in detail, the following case of *paralysis agitans* in the *Monthly Homœopathic Review* of December 2, 1901:

The patient, G. H., aged 54 years, for the previous two years had much anxiety of mind. He had been in the Indian service for nine years, when he had suffered from dysentery, and had also had a *soft* chancre. His present illness began two years ago. One evening he retired to rest in apparently good health, but awoke at dawn to find his left arm shaking violently and his head slightly. On attempting to walk he noticed a weakness of left arm and leg. After several days in bed, he improved so that he could ride his tricycle, the tremor became less and less, and the power of walking partially returned. A few months later he had a fall from his wheel, and was unconscious for some hours. He was seven days in the infirmary and came out with tremor of arm and leg as before. In March, 1901, he entered the London Homœopathic Hospital.

Condition on Admission—*Mental State*: Sensitive, timid, despondent man. Calls out frequently during sleep. *Speech*, slow, otherwise normal. *Sensorium*: Headache over each parietal region. *Organs of Vision*: No nystagmus, pupils react properly, muscular movement normal, arcus senilis well marked. *Hearing, taste and smell*, normal.

Sensory System: Band of hyperæsthesia at level of fourth lumbar vertebra. *Motor System*: Loss of power, flexors and extensors of left arm and leg. Rigidity of facial expression especially marked on movement. At rest, there is no tremor; on movement, moderately coarse tremor of left arm and hand and head, increased by attention called to it; can be nearly entirely controlled by the will.

Reflexes: Plantar sluggish on right side. Epigastric and abdominal absent on left side, normal on right. Patellar: normal on right, exaggerated on left. Sphincters normal. Otherwise a well man, so far as circulatory, respiratory and digestive systems are concerned. Urine normal.

Now, hypericum 6x was ordered for this man, and he was put to bed. With the exception of one prescription of *nux vom.*, for constipation, he received nothing but the hypericum 6x. He left the hospital April 27th, and reported afterwards at the out-patient department. His gait was then normal. Expression less rigid, and brighter. No tremor, no pain.

Dr. Goldsbrough regards the case as one of beginning *paralysis agitans*. The pain in the loin, the zone of hyperæsthesia and the other symptoms referable to the spinal cord, could be attributed to spinal traumatism. The action of the hypericum was striking in this case.

CYTISUS LABURNUM, A NEWLY-PROVEN REMEDY.—In the *Zeitschrift des Berliner Vereins Homöopathischer Ärzte*, Haft vi., January, 1901, Dr. Schier, of Mainz, presents a most interesting paper on "Cytisus Laburnum," a remedy that was proven first and exclusively by the Provers' Society of the Homœopathic Central Society of Germany, 1900–1901. A long list of toxicological reports is also given, and the physiological action and pharmacology is thoroughly reviewed.

The active principle, cytisin, is a highly poisonous alkaloid. It is also found in other plants, notably in the seeds of *baptisia tinctoria*. Every part of the plant seems poisonous, notably the rind and the roots. The fatal dose to a dog weighing 10 kilograms is 1.2–2 milligrams of the nitrate of cytisin. The physiological action is a profound depression of the psychic and animal spheres, preceded by a brief period of excitation. Death results from paralysis of the respiratory centre, heart's action continuing even after cessation of respiration, making it possible to restore life by artificial respiration.

Vomiting is a prominent symptom. Distressing, difficult, plainly audible respiratory efforts are associated with the nausea and vomiting. Vomiting is no doubt of central origin, although sufficient gastric irritation has been produced by the drug to induce it directly.

The vaso-constrictors are stimulated and the blood pressure is raised. Paleness, vertigo, violent headache, mainly left-sided and stitching, and nose-bleed are accompanying symptoms.

The cord and peripheral nerves are markedly affected by cytisin. At first there is an irritation similar to strychnine poisoning, namely, twitching of muscles, convulsions and tetanus. This is followed by motor paralysis, progressing from the centre to the periphery. The muscles are not affected by the poison. One of the most prominent symptoms experienced by the provers was heaviness and weariness in the lower extremities. Hyperæsthesia and sticking pains in the soles of the feet is a strong phenomenon observed by the provers. Dr. Schier mentions that a strong characteristic was the selective affinity for the left side manifested by the drug.

Fever, with cold sweat and cold extremities, was frequently seen in cases of poisoning; also dryness of the throat and constriction.

Dr. Schier believes cytisus may prove a valuable remedy in cerebro-spinal meningitis on the strength of the following symptoms: Irregular fever; intense headache; cerebral vomiting; abnormalities of the pupils; stiffness of the back of the neck; convulsions, followed by motor paralysis; difficult breathing and delirium. He compares it to *zincum cyanatum*.

In typhoid fever, particularly the meningial type, it bears promise. The close relationship of the remedy to *baptisia*, in the identity of their alkaloids, should be borne in mind.

Cocculus is similar in many respects, notably in vertigo; but in *cocculus* there is a fiery red, congested face, while in *cytisus* there is paleness.

Nux vomica and *cytisus* are very similar in their action upon the respiratory tract.

ARNICA IN ACUTE TONSILLITIS AND PHARYNGITIS.—Dr. Richard Haehl, of Stuttgart (*Homöopathische Monats-Blatter*, December, 1901), claims that *arnica* will check any case of acute tonsillitis or pharyngitis in the first stages if the following symptoms are present: Severe pain on swallowing, shooting

into the ears. The patient cannot take solid food, and finds it more comfortable to take large swallows of liquids than small ones. Difficulty in opening the mouth. The tonsils are swollen, bright red, and the process extends to the soft palate and uvula. The neck is swollen externally, and there is chilliness, aching and malaise.

TALKS ON ELEMENTARY THERAPEUTICS—RELATIONSHIP OF MERCURIUS TO RHEUMATIC FEVER.—We have reason to be grateful to this remedy for some cures of intractable cases of rheumatic fever; indeed, we would place mercurius in the front rank of the remedies most useful in the disease under consideration. The case for which mercurius is suitable will probably be of the type described as *subacute*—characterized by symptoms less violent than those of the typical acute case, yet pursuing a tedious, discouraging course, with perhaps relapses. Thus, the fever will be moderate, temperature running along at about 100, with slight visible joint-disturbances. There will not be much redness of the affected joints, nor much increase in the local heat; the joints may, however, appear puffed, but it will likely be a pale swelling, with perhaps a pinkish spot over prominent part of the joint, but no general redness. When we come to the *pain*, however, we shall find the mercurius pains intense and intolerable; much greater than one would suppose they should be, on account of the slight visible evidences of joint-inflammation. Now, here will come out very prominently the great characteristic of mercurius: "The pains are much worse at night." During the day there may be such an amelioration that you might suppose the case was getting on quite well. But, as night approaches, from sundown to sunrise, the pains will be so severe and sleep-destroying as almost to demand an anodyne. The patient cannot lie quiet for more than a few moments; even the bed-covers are intolerable on account of their weight, they feel so heavy to him. If a snatch of sleep should come, likely he will be awakened by jerking in the affected limb. The mercurius patient is bathed in a profuse sweat all night. This sweat is most offensive in odor, and, together with the offensive breath of the patient, makes him a rather unpleasant person. The tongue, thick, swollen, heavily coated with a dirty yellow fur; the breath distinctly "mercurial." We have seen such cases, running on for months under other remedies, getting a little better, then worse, until finally mercurius would clear up the case so that convalescence could be counted from the day of its administration. We have been in the habit of prescribing one grain of the third decimal trituration of mercurius sol. hah., every few hours, for such cases. Yes, as rheumatic fever occurs in this locality, one can scarcely get along without mercurius.

MENTAL SYMPTOMS OF LEAD POISONING.—Dr. Stewart Stalker reports, in *The Lancet*, the case of a plumber, aged thirty years, who was admitted to the Asylum suffering from poisonous effects of lead. He had marked delusions of persecution, with hallucinations of sight and hearing. He suffered from acute mania, being restless, noisy and excited. He was very much emaciated, certain muscles and groups of muscles being picked out. There was marked paralysis of the extensor muscles of the forearm, and wrist-drop was pronounced. He was unable to stand, and when held in the upright position his legs gave way from under him. Tremor was most noticeable when he attempted any movement. Anæmia was very pronounced and the face

wrinkled. A certain amount of optic atrophy was ascertained. There was also evident a certain degree of cirrhotic change in the kidneys, as there was an excessive amount of pale urine of low specific gravity passed daily.—*Monthly Hom. Review.*

PHOSPHORUS.—Dr. A. Berghaus had a practical little paper in the January number of *The American Physician*, in which, without much difficulty, he shows that when a remedy is prescribed simply for the symptoms as they are laid down in our much neglected materia medica, and not for the name or classification of a disease, we may look for success. He tells of a lady, forty or thereabouts, who suffered from an eczema extending from each ear into the scalp. He at first gave rhus tox. Then he prescribed graphites. Fortunately, as it afterwards proved, the patient developed a cold with a cough, which was relieved by pressure upon the chest. The cough seemed to shake her entire frame, and there was complete loss of voice. These and other symptoms suggested phosphorus to Dr. Berghaus. He gave that remedy in the 30x potency. Within a week, not only was she cured of her cough, but the eczema had almost entirely disappeared. Four years having elapsed, and no return, the doctor rightly concluded that she had been cured. Such cases are very suggestive. The lesson they convey should not be overlooked by homœopaths who are really interested in the success of homœopathy.

BELLADONNA IN TREATMENT OF PAIN DUE TO RENAL CALCULI.—*The American Physician* for January was full of good things. Dr. H. F. Biggar, of Cleveland, says that belladonna is the remedy *par excellence* for renal calculus during the attack of colic, providing the calculus is not unusually large. He also considers it a remedy for gallstone colic, or obstruction of the bowels, not resulting from adhesions or malignant growths. With some patients the attenuated dose is sufficient to give relief, while in others it may be necessary to give full doses, from twenty to forty minims of the tincture every hour or two, until symptoms of the physiological action of the drug are manifest, such as dryness of the throat, pupillary dilatation, etc.

The pain produced by renal calculi is more effectually relieved by bell. than by any other drug, opium not excepted. In bowel obstruction it may require more than the mere anodyne effects of the drug before the obstruction yields. An external application to the abdomen is more efficacious, especially when applied with iodine ointment. The formula is : Iodine ointment, one ounce ; extract belladonna, one dram ; mix and spread on lint, and apply to a part or the whole of the abdomen, as may be required. As soon as the iodine begins to irritate, the belladonna is more rapidly absorbed, and its action is much intensified. In these cases of renal calculi, Dr. Biggar recommends that the patient drink large quantities of Waukesha or Poland water, avoid red meats, and live temperately. (These remarks of Dr. Biggar were a part of the discussion in the Cleveland Hom. Soc.) If it be true that better results may be obtained from the physiological action of drugs, in such ailments as renal colic, than from the homœopathic action of attenuated remedies, then every homœopath will wish to know that fact, because he is anxious to do the best that can be done for the patient. But he wishes to be quite sure upon such matters ; that is all.

THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER.

A Medical Newspaper.

EDITED BY

HERBERT P. LEOPOLD, M.D.

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Outlines of Physiology. By Edward Groves Jones, M.D., Lecturer on Physical Diagnosis in the Atlanta College of Physicians and Surgeons, and Professor of Physiology in the Dental Department of the same. With 107 illustrations. 12mo., 400 pages. Published by P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia. Price, \$1.50 net.

This volume has been prepared with the view of presenting in as convenient form as possible the essential facts of modern physiology, as related to the practice of medicine. In the execution of this purpose, brevity has been the prime consideration; therefore such details as are of secondary importance are omitted, theories are avoided, and conclusions are recorded without argument. A maximum of space has been accorded those subjects which seem of most practical importance.

A System of Physiologic Therapeutics. A Practical Exposition of the Methods, Other than Drug-Giving, Useful in the Prevention of Disease and in the Treatment of the Sick. Edited by Solomon Solis Cohen, A.M., M.D., Professor of Medicine and Therapeutics in the Philadelphia Polyclinic; Lecturer on Clinical Medicine at Jefferson Medical College; Physician to the Philadelphia Hospital and to the Rush Hospital for Consumption, etc. In eleven octavo volumes. American, English, German and French authors. Volume VI.—Dietotherapy and Food in Health. By Nathan S. Davis, Jr., A.M., M.D., Professor of the Principles and Practice of Medicine in Northwestern University Medical School; Physician to Mercy Hospital and Wesley Hospital, Chicago; Member American Medical Association, etc. Published by P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia. 1901. Price for the set complete, \$27.50 net.

In this book the author has produced an eminently practical work on dietetics. The diet best suited in individual diseases has been fully described under the heading of each ailment. Although such a method embodies some repetition, it is unquestionably the one best adapted to the needs of the practitioner. In addition to this, the principles underlying diet and nutrition are systematically presented. The thoroughness with which this branch of the subject has been reviewed may be appreciated by the presentation of the headings of the various chapters under "General Principles of Diet and Diet in Health." I. Food in Health. II. Use of Water in Dietetics. III. and IV. The Elements of Food. V. Quantity and Kinds of Foods Needed in Health. VI. and VII. Animal Foods. VIII. Vegetable Foods. IX. Beverages. X. Diet in Health. XI. and XII. Infant Feeding. XIII. Food as a Cause of Disease.

Gynæcological Pathology: A Manual of Microscopic Technique and Diagnosis in Gynæcological Practice, for Students and Physicians. By Dr. Carl Abel, Privat Dozent in Berlin. Translated and edited by Samuel Wyllis Bandler, M.D., Adjunct Gynæcologist to the Beth-Israel Hospital, New York. With a chapter on the Embryology of the Female Genitalia and Pathological Growths Developing from Embryonal Structures. New York: Wm. Wood & Co. 1902. Price, \$2.50.

Bandler's translation of the "Gynæcological Pathology" by Abel is a book which must be greeted with much satisfaction by the English-speaking medical profession. It fills a place which has long remained vacant in our literature, since we have no work which so completely and comprehensively deals with this branch in English.

The first section describes the pathologic technique, and contains many points that are exceedingly useful to the general practitioner, and many subjects of reference which even a skilled pathologist finds impossible to carry in his mind, such as the formulæ for the various fixing and staining solutions.

Considering the normal histology, Abel then accurately and at length studies the deviations which we find in the different pathologic conditions of the various organs of the female genitalia.

The chapter which so clearly deals with erosions and carcinoma of the cervix uteri is most important to the physician, because in his hands very often rests the early diagnosis of malignancy, and therefore the hope of cure for the patient.

A most useful part is that treating of the changes in the endometrium during menstruation and pregnancy, and the microscopic picture of the scrapings of the uterus following abortion.

The last section, giving us the embryology of the female genital organs,

although not of the same practical value as the other parts of the book, is nevertheless a subject which every specialist in gynecology considers a necessary addition to his knowledge of the branch. This part of the work is certainly one of the most interesting to the student of gynecic pathology, and it gives him knowledge that he cannot obtain so well classified and stated in any other work known to us in the English language.

We can safely say that we have in Abel's "Gynecological Pathology" a book that should be on the shelves of every one doing any gynecologic work, and one that will give complete satisfaction whenever used as a book of reference.

Psychopathia-Sexualis, with Especial Reference to Antipathic Sexual Instinct. A Medico-Forensic Study.—By Dr. R. v. Krafft-Ebing. The only authorized English translation of the tenth German edition, by F. J. Rebman. Chicago: W. T. Keener and Co., 90 Wabash Avenue. 1901. Price, \$5.00.

This is a book which, so far as we can see, is not capable of serving any useful purpose, so far as physicians are concerned. In the edition extensively circulated in America several years ago, much of the nastiness was left untranslated or was presented in French. The present edition is a full translation. How any one can wade through the tedious narration of the misfortunes and unfortunate condition of the sexual perverts is past all comprehension.

The mechanical make-up of the book is as fine as we have ever seen among medical books; fine plate paper, stylish and strong binding, gilt edges, etc. Truly a good cover for the nastiness within!

New York Letter.—The regular meeting of the Academy of Pathological Science was held on Friday evening, January 24, 1902, at 8.30 o'clock, at the residence of Dr. A. B. Norton, 16 West 45th Street. The following gentlemen were elected to membership: Dr. A. F. Thompson, 169 Main Street, East Orange, N. J.; Dr. John E. Wilson, 23 East 45th Street.

Program for discussion was: Dr. E. D. Simpson, Suggestive therapeutics. Methods employed, demonstrated on two patients. Dr. W. T. Helmuth, Jr., Two anomalous cases of appendicitis. Dr. Geo. W. Roberts, Cancer of rectum. Specimen, with microscopic sections. Multiple fibroids of uterus. Specimen. Dr. E. G. Tuttle, Sac of inguinal hernia; congenital absence of testicle; tubercular testicle. With microscopic sections. Dr. Geo. F. Laidlaw, Syphilitic disease of cerebral arteries, from Dr. Mills' case of hemiplegia. Anomalous development of right anterior cerebral, with microscopic sections. Kidney of acute nephritis; accidental death; microscopic sections. Thrombosis of right lateral sinus, longitudinal sinus and right auricle; caseous pneumonia, caseous bronchial and mesenteric lymph glands and caseous nodules in liver and spleen; with microscopic sections.

The regular meeting of the County Society was held on Thursday, February 13, 1902, at 8 o'clock P.M. The following were elected to membership: Caleb Barker, M.D., Hahnemann Hospital; Merritt I. Beers, M.D., Metropolitan Hospital; Homer C. Brigham, M.D., 107 Central Park, West; Geo. Franklin Brewster, M.D., Metropolitan Hospital; Daniel E. D. Coleman, M.D., Metropolitan Hospital; L. W. Dean, M.D., 201 East 23d Street; David M. Gardner, M.D., Metropolitan Hospital; Ralph J. Iszard, M.D., Metropolitan Hospital; Robert M. Jones, M.D., 130 West 48th Street; Wm. P. Lang, M.D., Metropolitan Hospital; P. H. J. Lerrigo, M.D., 288 Lexington Avenue; Wm. C. McKnight, M.D., 3 Mount Morris Park; R. E. Mitchell, M.D., Metropolitan Hospital; Samuel B. Moore, M.D., Metropolitan Hospital; C. Winfield Perkins, M.D., Metropolitan Hospital; W. B. Roberts, M.D., Hahnemann Hos-

pital; Guy B. Stearns, M.D., Metropolitan Hospital; Roy Upham, M.D., Hahnemann Hospital; Wm. M. Van Zandt, M.D., 107 East 62d Street.

The following papers were read: "Classification and Diagnosis of Inflammation of the Kidney," Louis Heitzmann, M.D. Discussion opened by Dr. Geo. M. Dillow. "The Eye Symptoms of Chronic Nephritis," E. H. Linnell, M.D., of Norwich, Conn. Discussion by Drs. F. H. Boynton and A. B. Norton, with exhibition of paintings of morbid retinae by Dr. Boynton. "Therapeutics of Nephritis." Discussed by Drs. B. G. Clark, Thomas M. Dillingham, C. S. Elebash and J. T. Simonson.

On Friday, January 31, the City of New York opened a tuberculous hospital on Blackwell's Island. The new pavilion for consumptives is not far from the main building of the Metropolitan Hospital, and contains 120 beds. The Commissioner of Public Charities has turned it over to the Medical Board of the Metropolitan to run. The following men have been assigned to duty: Drs. Egbert Guernsey Rankin, John W. Dowling, Ephraim D. Klots and Walter Sands Mills.

The City of New York is the first municipality in the United States to set apart a separate institution for the treatment of consumptives, although a number of States have such places either established or in contemplation. The immediate supervision is in the hands of the homœopathic profession. This is one of the most important happenings pertaining to the school in many years.

Rochester News.—The winter meeting of the Western New York Homœopathic Medical Society was held at Rochester, January 10th, and proved a very interesting and well-attended meeting. The President, Dr. N. M. Collins, was in the chair. The following papers were read and discussed:

"Disturbances of Equilibrium," by Dr. Elmer J. Bissell, Rochester. After the reading of this paper the society voted unanimously that it be sent to *THE HAHNEMANNIAN MONTHLY* for publication.

"Some Causes of Convulsions in Infants and Children," by Dr. Emily F. Swett, Medina. Discussed by Dr. G. R. Stearns, of Buffalo.

"The Importance of Microscopical Examination of the Urine," by W. C. Daly, of New York City. Discussed by Dr. G. R. Critchlow, of Buffalo, and Dr. W. W. Winans, of Rochester. Dr. Critchlow mentioned several cases of gross inaccuracy in urinary examinations made by reputable physicians, where careful examinations revealed serious conditions present, and materially altered the diagnosis. Dr. Critchlow considered the picric acid test for albumin more delicate than the heat and nitric acid tests. The absence of albumin in the urine did not denote the absence of renal disease. The desirability of obtaining a twenty-four hours' sample was also mentioned.

"Rupture of the Ovarian Artery and Fallopian Tube," by Dr. F. P. Warner, of Canandaigua, was the next paper presented. It was discussed by Drs. S. R. Snow and J. M. Lee.

Dr. E. J. Bissell proposed that the meetings of the Society be changed from three to two each year, mentioning as a reason the chance for conflicting dates of the various sectional and county societies.

The names of Dr. Grace A. B. Carter and William Perrine were proposed for membership.

One of the pleasant features of the meeting was the presentation to the Society of a beautifully carved and inlaid box for the reception of the gavel by Dr. Emily F. Swett, of Medina, who had at a previous meeting presented the gavel to the Society.

Dr. J. W. Le Seur, of Batavia, on behalf of the Society, then thanked Dr. Swett in a few well-chosen words, and the meeting adjourned.

The annual meeting of the Monroe County Homœopathic Medical Society was held January 21, 1902, at the Homœopathic Hospital. There was a good attendance, and the meeting was one of decided interest and profit. "Drug Action as Applied to Homœopathy" was the subject of a paper read by Dr. W. F. Clapp, Fairport, and sections 214-216 of the *Organon* were discussed by Dr. P. W. Neefus. An address by the President, Dr. Marcena S. Ricker, was read, and Dr. J. M. Lee gave a paper on "Much-Needed Suggestions from the Standpoint of the Surgeon."

Dr. Lee's paper dealt with vexed questions of interest both to the professional and popular mind. It provoked considerable interest and discussion. Extracts from the paper follow :

"It is safe to state that two-thirds of the mortality in the treatment of surgical diseases is due to neglect on the part of the patients themselves. They seem to think that the profession usually makes mistakes in its diagnosis, or that the diseases by some unknown means will take care of themselves. Again, they believe that physicians are unduly anxious, or that they have some ulterior motive in sounding the alarm ; therefore, they fail to avail themselves of prompt and appropriate treatment.

"This is especially true in the case of appendicitis, though it has not been understood until the last five or ten years ; the profession and the laity have been slow to avail themselves of modern treatment. I have no doubt that the position that the press took upon this disease had much to do with retarding the spread of appropriate treatment.

"Some of the medical profession may still teach that surgical treatment is not indicated in appendicitis, and the laity throughout the country may have too largely indorsed the opinions of these 'conservative' physicians, so-called, and too frequently refuse to accept timely operations. It will take a few more years for us to become better informed as to the diagnosis and early treatment of this disease.

"This last proposition, early treatment, is the all-important one, but it is most difficult sometimes to determine just when the operation should be performed, or, in non-perforative cases, whether surgical treatment should be resorted to at all. Therefore, when doubt exists, it is infinitely better to employ the exploratory incision to clear up the diagnosis.

"Now, as a matter of fact, the exploratory incision is often employed. The honest surgeon will be frank with his patient and tell him that he cannot diagnose the case accurately, but he believes that appendicitis exists and that it is necessary for him to make an incision to be absolutely certain. It carries but 1 per cent. of danger, and it is only about once in a hundred times that the surgeon is deceived as to the true nature of the case ; hence, the exploratory incision proves to be the first step in the necessary curative operation."

Dr. Lee then dealt with tumors, goitre, cancer and similar diseases, concluding by emphasizing the importance of early treatment in all surgical diseases.

In the course of her address, the President said :

"The title of M.D., doctor of medicine, carries with it a sacred responsibility. The physician's mind should be imbued with the greatness of his mission and the responsibility he constantly incurs in its discharge. The opportunity which a physician not infrequently enjoys of promoting and strengthening the good resolutions of his patients, suffering from the consequences of his vicious conduct, ought never to be neglected. His counsels or even remonstrances will give satisfaction, not offense, if they be proffered with a genuine love of virtue accompanied by a sincere interest in the welfare of the person to whom they are addressed.

"It is a narrow, low conception of a physician's duties to consider that they

consist merely in giving professional opinion, prescribing for the difficulty and collecting the fee. The sacredness of the position which he or she occupies in the house and in the community makes it true that there is no profession, not even the ministry, from the members of which greater purity of character and a higher standard of moral excellency is required than that of the medical profession.

"No scientific attainments can compensate for the waste of correct moral principles. A steady hand and unclouded head are essential to the well-being, yes, even to the life, of a fellow creature. The fundamental principle upon which medical ethics is based is that embodied in the best of all rules, the golden rule. To the physician is intrusted that most sacred gift, life. If our life is in jeopardy, or if disease assails the life of a dear one, we wish no half-hearted effort put forth to help rescue that life. We desire earnest, noble effort.

"There is a great difference between the victories won by a physician and those won by other people. He meets his antagonist in the silent bedchamber, unobserved by spectators, with no words spoken, no flourish of trumpets, and usually no other mention made. Emergencies come upon him in a moment, he has no chance to consult authorities, life is in the balance, hæmorrhage must be stopped, collapse counteracted, poison antidoted, the fires of fever extinguished, and, when all is over, he alone may be conscious that a crisis has been met and a victory won."

It was resolved by the Society that each individual member and the Secretary should write at once to the Monroe county legislators in the State assembly, asking them to oppose the bill vesting the power of appointing a superintendent of the State hospitals in the Governor, and the bill to legalize the practice of osteopaths. A committee was also appointed for the purpose of conferring with the committees from the other medical societies of the city and county, for the purpose of suppressing the practice of unqualified practitioners.

The officers chosen for the following year are : *President*, Dr. W. H. Doane ; *Vice-President*, Dr. W. S. Rambo ; *Secretary*, Dr. Llewellyn J. Sanders ; *Treasurer*, Dr. Herbert A. Anderson ; *Censors*, Drs. M. S. Ricker, W. B. Carman and W. W. Winans.

At the annual meeting of the Board of Governors of the Rochester, N. Y., Homœopathic Hospital and Dispensary, the term of service of the internes of the hospital was changed from two years to sixteen months. This provides that each of the four internes spends four months as Junior House Physician, Junior House Surgeon, Senior House Physician and Senior House Surgeon, respectively, and that the sum of \$50 be paid to the Senior House Surgeon on the completion of his sixteen months' service. There are to be three appointed each year.

Dr. T. D. Spencer, who was President of the Medical and Surgical Staff of the Hospital and Dispensary last year, was appointed to serve another year. Dr. H. G. Shepard was added as one of the surgeons of the Dispensary Staff.

The annual Homœopathic Hospital meeting was held January 15th. Some extracts from the Secretary's report are as follows :

Patients cared for in the Hospital for past year, 1646—an increase of 72 over last year.

Patients treated in the Dispensary, 1848.

Ambulance calls, 1094—77 more than last year.

The Treasurer's annual report showed a balance in the treasury of \$5062.10.

All of the reports were of a most encouraging and satisfactory nature, the more so since the Hospital's organization.

Wm. W. Wianns, M.D.

Announcement. American Institute of Homœopathy.

OFFICE OF THE SECRETARY, 100 State St., Chicago,
FEBRUARY 20, 1902.

To the Members of the American Institute of Homœopathy:

The President of the American Institute is able to announce that it is now possible to forecast, to a great extent, the conditions which will attend the holding of the Fifty-eighth Annual Meeting of our great National Association, to be held in Cleveland, Ohio, June 17 to 21, 1902.

The local headquarters will be at the Hotel Hollenden, which is one of the finest hotels in the United States, and in its arrangements and appointments is peculiarly well adapted to the purposes of the meeting. The house and its furnishings may be termed elegant, and its cuisine is of the best. A new addition is being built, which will be ready for occupancy in June. The hotel will accommodate 700 guests. A special reduced rate for rooms will be made for Institute members. The Hollenden is on the European plan. The "Colonial," across the street, is another first-class hotel, and can accommodate a large number. It is on the American plan. Other smaller hotels are conveniently near.

The hall for the meetings, in the Chamber of Commerce building, not far from the Hollenden, is splendidly adapted to the Institute's purposes. The hall is large—seating 1000—it has attached to it numerous committee rooms, and, what is of especial interest and importance, it is quiet, being entirely out of hearing of the noises incident to traffic in the busy city streets.

At the present time there is favorable prospect that the several allied Societies will combine with the corresponding Sections of the Institute, by mutual agreement between the officers of the various bodies, so that this year their work will practically be a part of the work of the Institute. This is looked upon as being a fortunate arrangement, and one that will add greatly to the interest of the coming meeting.

It is hoped to have, as a special feature of the meeting, a "College Alumni Conclave." This, if arrangements are completed, will be held under the auspices of the Institute authorities, and, while affording every opportunity for the enjoyment of the occasion, it will differ in important respects from alumni reunions which have been held in the past. The alumni of the various Colleges will, upon arrival in Cleveland, register at headquarters, which will be provided for them by the Committee of Arrangements, at the Hollenden. On Thursday evening the General Conclave will be held at the Chamber of Commerce Hall. It is especially desired that the women graduates of our co-educational institutions shall take part. The program for the evening's entertainment will be arranged by the Special Committee, acting in conjunction with the Institute authorities. The entertainment will consist of appropriate music, orchestral and quartette, and the singing of college songs, together with brief speeches by representatives of the various Colleges. In addition to this feature, the Local Committee of Cleveland will, for the several days of the meeting, provide appropriate entertainments of various kinds, which, while not conflicting with the Institute sessions, will afford diversion suited to all.

The location of Cleveland is especially favorable. It is easily accessible from the East, from the South, from the West and from Canada. It is a convenient, common meeting-place for all. It is, as yet, too early to announce the arrangements that will be made with the various railroads in the matter of reduced rates of fare. These will be made known in due time.

Cleveland is a city which is more than usually well adapted for convention purposes for a body the size of the American Institute of Homœopathy. It

is pleasantly located on the shore of Lake Erie. It has wide streets lined by many shade trees, beautiful drives and parks, fine hotels, golf links, club houses, and every attraction possible to offer by any place aspiring to entertain such a body as our National organization. The local profession is united, harmonious and enthusiastic in the work that is given them to do. They are making every preparation and looking forward with anticipations of the greatest pleasure to becoming the hosts of the Institute on this important occasion. There is not a cloud in the sky. All promises well, and there is every prospect that our meeting in Cleveland will be a large one in the matter of attendance, harmonious in its labors, enthusiastic in the spirit that will prevail, and in all respects one of the most successful ever recorded in the Institute.

The Executive Committee is thoroughly convinced, and more than ever satisfied, that in the best interests of the Institute it has made absolutely the wisest choice in selecting Cleveland for the next place of meeting.

James C. Wood, M.D.,

President.

Ch. Gatchell, M.D.,

Secretary.

Washington Letter.—*Washington Homœopathic Medical Society.*—The regular monthly meeting of the Washington Homœopathic Medical Society was held at the Willard on February 5th, at 8.30 P.M. It was the first meeting since the election of new officers, following the valedictory address by the retiring President. The Chair appointed Drs. Gilbert and Hawxhurst to conduct the President-elect, Dr. G. W. N. Custis, to the chair, and the new officers took charge of the meeting. Dr. Custis then read a very much appreciated "Address," going largely into the past history and influence of the Society, and asked for united support of the Society, which was, he said, the only way to best further its desired ends. Following this, the Society enjoyed a symposium on "Uricacidæmia," papers being presented on the subject by Drs. Woodward, King and Hawxhurst, the first two dealing largely with the condition from an ophthalmic view-point, while Dr. Hawxhurst's paper went into the newer xanthin theory of gouty conditions. All papers were enthusiastically received and freely discussed by the various members present.

Before adjournment the President announced the March meeting would be devoted to the subject of small-pox, its early diagnosis and treatment.

The preliminary notes on the virulence of bovine tubercle bacilli, by E. A. de Schweinitz and E. C. Schroeder, have recently been published under the supervision of Dr. D. E. Salmon, Chief of the Bureau of Animal Industry, Washington, D. C.

Dr. Presley M. Rixey has been appointed Chief of the Naval Bureau of Medicine and Surgery, with the rank of Rear-Admiral, vice Rear-Admiral Wm. K. Van Reyden, who is retired by request, after forty years' service. This appointment is in recognition of Dr. Rixey's services rendered to the late President McKinley.

Health in the Philippines.—The health report of the Division of the Philippines for the month ending November 15th, received at the Surgeon-General's office, shows 650 sick in quarters, 1024 in regimental hospitals, and total incapacitated of 2952, the per cent. of sick to the command being 6.79.

The Medical Society of the District of Columbia at a recent meeting elected the following officers for the ensuing year: Dr. Samuel S. Adams, *President*; Drs. J. W. Chappell and A. R. Shands, *Vice-Presidents*; Dr. C. W. Franzoni, *Treasurer*; Dr. Thomas C. Smith, *Corresponding Secretary*; Dr. Francis P. Morgan, *Recording Secretary*; Dr. Edward L. Morgan, *Librarian*.

Against Opium Smoking.—A bill will shortly be introduced into Congress prohibiting the importation of opium manufactured for smoking. Before any package exclusively containing opium can be passed, an affidavit must accom-

pany it to the effect that it is solely for medicinal purposes. Violation of these requirements will entail forfeiture of the opium, with a fine of not to exceed \$500, or imprisonment of not more than one year.

Health of the District.—The report of the Health Office for the week ending January 25th shows the number of deaths 122. Of these, 64 were white and 58 colored. At the close of the week there were 42 cases of diphtheria, 34 cases of scarlet fever and 2 cases of small-pox under treatment; 101 births were recorded.

The Care of Sick Poor.—The Associated Charities of the District recently held a conference looking to better care of the indigent sick, the purpose being to aid worthy poor in need of medical attention, and yet shrink from the painful notoriety now given cases applying for charity treatment. The Secretary of the Charities discussed the methods, ways and means with various members of the profession and prominent men of the District. Resolutions were adopted to be presented to the Medical Societies of the District for approval.

Anti-Spitting Regulation.—The health authorities of the District have held in abeyance the promulgation of a police regulation prohibiting expectoration upon the sidewalks.

The Oleomargarine Bill.—The House Committee on Agriculture who are investigating the proposed oleomargarine legislation gave a hearing to Dr. George M. Lober, of Georgetown University, at a recent meeting. The doctor favors its passage, and argued for its general healthfulness.

Projected International Health Service.—Passed-Assistant Surgeon Milton J. Rosenau, director of the United States Marine-Hospital Service Hygienic Laboratory, and recently appointed Special Commissioner to Pan-American Congress at City of Mexico, has gone to Mexico, where he will appear before the Committee on Sanitation to give expert testimony relative to the proposed establishment of an international health service among the American republics.

The Enteric Fever Bill.—The House Committee has favorably reported the typhoid fever bill known as H. R. 8759, which has been amended so as to read as follows:

That every physician attending or called in to visit or examine any case of typhoid fever in the District of Columbia shall at once send to the Health Officer of the District a certificate in ink, signed by him, stating the name of the disease, and the name, age, sex and color of the person suffering therefrom, and setting forth by street and number or otherwise sufficiently designating the house, room or other place in which the person can be found, together with such other reasonable information relating thereto as may be required by the Health Officer; and upon the recovery or death of such patient the physician in attendance shall, within twenty-four hours after he becomes aware of such recovery or death, forward to the Health Officer a similar certificate, certifying thereto.

Any person violating any of the provisions of this act shall, upon conviction thereof, be deemed guilty of misdemeanor, and shall be punished by a fine not exceeding \$100. All prosecutions under this act shall be in the Police Court of the District, upon information brought in the name of the District of Columbia and on its behalf. All acts and parts of acts contrary to the provisions of this act, or inconsistent therewith, are repealed.

Bill for Modification of Sale of Poisonous Drugs in District.—The draft of a bill to restrict the sale of poisonous drugs in the District of Columbia has been prepared by Dr. William C. Woodward, the Health Officer, who claims that legislation on this subject is urgently needed. The bill has been submitted to

the attorney for approval as to its legal form, and will later be presented to Congress. Among other things, the bill provides that no person shall retail any drug or drugs in quantity containing a toxic dose for an adult, unless the receptacle containing the drug is plainly labeled with the popular name of the drug, directions for its use, and an intelligent statement as to the treatment, if poisoned thereby. The person to whom the poison is sold, without a prescription from an authorized physician, must be over 16 years of age, be intelligent as to the nature of the drug, and must certify that it is to be used for a legitimate purpose. In a book kept for the purpose must be entered the date of sale, the names and addresses of the persons to whom delivered and for whom intended, the name and quantity of the poison sold, the purpose for which it was intended, and the name of the dispenser. This book must be open for inspection by the police, and must be kept at least five years after the last entry is made. Persons habitually addicted to the use of drugs shall only obtain them upon a written prescription by a physician. Also records must be kept of all prescriptions. On the outside of the receptacle holding the prescription must be legibly written the number, date on which it is made up, directions for its use or other memoranda given by the prescribing physician, the name of such physician, and the place where the prescription was dispensed.

Macpherson Crichton, M.D.

Died.—Dr. Alonzo Boothby died suddenly at his home in Boston, February 8th, of angina pectoris.

Removal.—Dr. E. Hasbrouck has removed to 389 Fourth Avenue, Brooklyn, N. Y.

Practice for Sale.—Any one wishing to locate in Washington, D. C., can secure a homœopathic practice, established for twenty years, by renting or buying the premises for one-half the actual value. Everything adapted specially for office work or private sanitarium. Address, Dr. Geo. E. Connell, 3230 N Street, Washington, D. C.

The Saturday Night Club of Microscopists.—The annual meeting of the Club was held January 18, 1902, at the Hahnemann Medical College. The election of officers resulted in the selection of Dr. J. C. Guernsey, *President*; Dr. John J. Tuller, *Vice-President*; Dr. Nathan Smilie, *Secretary-Treasurer*. *Board of Censors*, Dr. F. O. Gross, Dr. J. E. Bellville, and Dr. E. W. Mercer.

Among other business transacted, the Club voted to buy an electric projection lantern for its own use.

The Secretary-Treasurer made a very favorable report on the membership and financial standing of the Club. The number of members, 57; new members added during last year, 3. Two old members were reinstated. Three proposals for membership at this meeting. After paying for the new specimen cabinet and all outstanding bills, the treasury shows a good-sized balance. The annual dues were last April raised to \$2, and there was a quick response from the active members of the Club. Up to date nearly half of the Club have paid their 1902 dues in advance.

Dr. J. E. Bellville gave an excellent demonstration of the "Pathologic Histology of Tonsils and Adenoids," illustrated by a collection of fine microscopic sections.

Dr. H. S. Weaver followed with a short talk on "The Etiology and Prognosis of Hypertrophied Tonsils and Adenoid Growths." There was a goodly number present, and much interest shown in the discussion following the demonstration.

Nathan Smilie, M.D.,
Secretary.

The Thirteenth Regular Monthly Meeting of the "Raue Medical Club" of Central Pennsylvania was held at the residence of Dr. J. K. Wrigley, 1500 Fourth Avenue, Altoona, Pa., February 5, 1902.

The following members were present: Drs. Morrow, Baker, Wrigley, Taylor, Blackburn, Bohn, and Hoy, of Altoona, and Drs. Stitzel and Humes, of Hollidaysburg.

It has been the desire of the Club for some time to establish a Homœopathic Hospital in Altoona for the convenience of the homœopaths of Central Pennsylvania, who must take their operative cases either to Philadelphia or Pittsburgh. The question was thoroughly discussed and a committee of three appointed to look up locations, cost, etc. The committee is Dr. Morrow, President, and Drs. Hoy and Blackburn.

This was followed by the reading of a paper by Dr. Wrigley on "Delirium Tremens," illustrated by a case from practice. This was followed by a general discussion.

The Club decided to accept the invitation of Dr. McDonald, of Johnstown, to hold its next meeting at his place. Adjourned.

Daniel Bohn, M.D.,
Secretary.

The Massachusetts Homœopathic Hospital.—At the annual meeting of the Massachusetts Homœopathic Hospital, held January 29th, the need of more room to meet the growth of its work was emphasized by President Charles R. Codman in his report. During 1891, 2607 patients were treated at the hospital, the record number, and 323 more than during 1900. The report of the Trustees recommended that a contagious ward be established.

The report of the Medical Board emphasized the need of money for the erection of at least four new buildings. The following officers were elected:

President, Charles R. Codman; *Vice-Presidents*, John C. Haynes, David B. Flint, Spencer W. Richardson and Conrad Wesselhoeft, M.D.; *Trustees*, Ezra H. Baker, Everett W. Burdett, J. Wilkinson Clapp, M.D., Preston Clark, Elisha S. Converse, Henry B. Day, M. F. Dickinson, Arthur F. Estabrook, Edward H. Haskell, George H. Leonard, Samuel P. Mandell, Edward H. Mason, William Taggard Piper, Henry Bigelow Williams, Mrs. T. B. Aldrich, Mrs. Francis R. Allen, Miss Helen Collamore, Mrs. E. S. Converse, Mrs. A. S. Foster, Mrs. George W. Gregerson, Mrs. John C. Haynes, Miss F. E. Horton, Miss Ida Hummaman, Mrs. M. P. Kennard, Mrs. George D. Tyson, Mrs. Edward Whitney, Mrs. Alfred S. Woodworth; *Treasurer*, Charles H. Watson; *Secretary*, Erastus T. Colburn. The *State Trustees* are: William L. Morse, N. Emmons Paine, Henry F. Harris, Erastus T. Colburn and Sydney M. Hedges.

The Philadelphia Medical and Surgical Society.—In reviewing the work of the Philadelphia Medical and Surgical Society for the past year, at the annual meeting on January, 15, 1902, the President, Dr. John J. Tuller, commented particularly on the excellent work done by the Society, urging at the same time that the coming year should, if possible, be more productive even than the past—congratulating the Society that each individual member seemed to vie with the others in producing the most advanced and scientific investigations of the subjects presented, and taking extreme pleasure in illustrating his subject with as perfect a clinical case, for demonstration, as he could find. He further urged that each member, being notified of the subjects to be presented at the successive meetings, should make a special effort to prepare himself to enter into the discussion of the subjects presented from the standpoint of his special line of work, that we should have the scientific presenta-

tion of the different clinical cases presented from the ground of every specialty in medicine, as every member of the Society is requested to enter into the discussion. The result of such a plan of conducting these meetings has proven to be not only a most interesting, but a most instructive one. The discussions being reported stenographically, the plan has been formulated that the papers and discussions shall be reduplicated and bound, that each member of the Society shall have a copy for filing and reference in his office.

It has been necessary to create two new memberships this year, the one, Biology, filled by Dr. J. E. Bellville, and the other, Toxicology and Chemistry, filled by Dr. Charles Platt.

Following is a statement of the year's subjects presented:

February 20th. Dr. D. B. James, "Conservative Treatment in Inflammatory Conditions of Female Pelvis."

March 20th. Dr. H. P. Leopold, "Diseases of the Osseous System."

April 17th. Dr. F. C. Benson, "Importance of Early Diagnosis and Treatment of Breast Tumors."

May 14th. Dr. E. W. Mercer, "The Importance of Pelvimetry."

June 19th. Dr. Wm. Spencer, "Cataract."

October 16th. Dr. J. J. Tuller, "A Clinical Study of Locomotor Ataxia."

November 20th. Dr. W. W. Van Baun, "Care of Children with Mitral Lesions."

December 18th. Dr. H. S. Weaver, "Hypertrophied Tonsils."

The Atlantic City Homœopathic Medical Club met January 17th at the Hotel Dennis for their annual meeting and banquet. Twelve members and their ladies were entertained as guests of Drs. Fleming and Westney. Those present were: Drs. Bailly, Balliett, Bewley, Fleming, Gardiner, Hood, Hughes, Jackson, Lyon, Munson, Sooy and Westney. Dr. Jackson read the paper of the evening on "Erysipelas," which was freely discussed, after which a fine banquet was served. The following officers were elected for the year 1902: *President*, Dr. Wm. G. Gardiner; *Secretary*, Dr. M. S. Lyon; *Treasurer*, Dr. Wm. G. Sooy.

M. S. Lyon, M.D..

Secretary.

Notice.—ROCHESTER, N. Y., Feb. 5, 1902.—A competitive examination for internes of the Rochester Homœopathic Hospital will be held in Rochester on the *third Saturday of March*, 1902. Candidates will please report at the Hospital, 224 Alexander Street, at 10 A.M. The term of service will be *sixteen months*. There will be three vacancies, one each on June 15th, October 15th and February 15th.

Address all correspondence to

Herbert W. Hoyt, M.D..

Secretary of Staff of Rochester Homœopathic Hospital.

75 South Fitzhugh Street.

Substitution Extraordinary.—Substitution extraordinary is illustrated in a history supplied by the Farbenfabriken of Elberfeld Company, who have been able to ferret out a most despicable adulteration of chemicals practiced by a band of drug counterfeiters. Not only were the products themselves imitated, but the boxes, labels, etc. Druggists buying aristol, phenacetin, sulfonal, trional, etc., should be on their guard against sophisticated articles. The protest of the manufacturers rightly contends that "both the physician's reputation and the welfare of his patient are at stake in this matter. When, therefore, we protect ourselves against these criminal practices, we believe that we are equally protecting the medical profession."

THE HAHNEMANNIAN MONTHLY.

APRIL, 1902.

URÆMIC ECLAMPSIA: SOME FACTS AND OBSERVATIONS.

BY ARTHUR PALEN POWELSON, M.D.,

Resident Physician, Rochester Homœopathic Hospital, Rochester, N. Y.

(Read before the Homœopathic Medical Society, State of New York, Albany, 1902.)

PURDY claims the general cause of eclampsia lies in the failure of the kidneys to excrete the urine in part or whole, and that the urine, or its primary elements, acts as direct toxins upon the organism, evoking symptoms termed uræmic.

It is not my intention to set forth in this paper the causes of eclampsia, or to discuss the already advanced theories concerning its origin, but rather to present, in a clinical way, cases observed by me during my service as house physician at the Rochester Hospital.

No class of disease in the domain of medicine presents more alarming manifestations or terrifying symptoms than those due to uræmic poisoning; especially is it true of the eclampsia of parturient women.

This dreaded disease happily was at first considered to be of rare occurrence, but recent investigations tell us only too plainly that puerperal eclampsia is much more frequent than was formerly supposed; in fact, so much more so that every practitioner is almost certain to meet with it sooner or later during his career.

Kaltenback estimated that it was found once in 500 pregnancies; Auvard, as occurring 3 times in 1000 cases; while the

statistics of the Philadelphia Board of Health (1868-1873) show the occurrence of eclampsia once in every 170 labors.

The laity, as a rule, look upon all cases of labor as being perfectly natural and normal, and can and will not overlook a fatal issue. This fact is, then, of momentous import to the young physician whose reputation is yet to be established, as the loss of a case may ruin his prospects in the community in which he resides. It is, therefore, of the utmost importance to recognize early the symptoms of uræmic poisoning, and to employ the best known methods to bring about its proper elimination. The symptoms of the pre-eclamptic state should be especially looked for in primiparæ. On account of the greater intra-abdominal pressure, longer labor, and the more extreme nervous excitation, first pregnancies are more predisposed to convulsive seizures.

In three cases coming under my observation, and which I now cite, all occurred in primiparæ, and are especially interesting on account of the severity of the symptoms. One occurred during pregnancy, one during labor, and the other after its termination. Two were admitted to the hospital in a state of coma, with a history of no previous medical attention.

CASE I.—Age, 20; nativity, U. S.; gestation, 8th month. Admitted Sept. 8, 1901, at 6 P.M. Unconscious. Temperature, 104°; pulse, 140; respiration, 38. Two days before was taken with convulsions, which occurred at frequent intervals, followed by coma. The doctor first called was unable to diagnose her case, but prescribed for her, nevertheless. She soon grew alarmingly worse, and another physician was sent for, who immediately recognized her condition and brought her to the hospital. As soon as admitted she was catheterized. Six ounces of urine were drawn, densely loaded with albumin, and showed sp. gr. 1010; urea, .002. Patient had numerous convulsive seizures, lasting three minutes, until 12 P.M., when she was forcibly delivered (podalic version) of a dead child. Verat. vir., θ , drop doses, prescribed every hour. She had, during the night, sodium brom., grs. xx; chloral, grs. xv; pilocarpin, grs. $\frac{1}{10}$ (hypo); strychn., $\frac{1}{25}$. A hot pack was used four times. Poland water, oz. vi, and milk, oz. ii, were ordered every hour during the night, when able to swallow. Saline enemas were given, 1 pint every four hours. Sept. 9th, 6 A.M., temperature,

103 $\frac{2}{5}$ °; pulse, 135; respiration, 35. In profound stupor most of day; only aroused once, for a moment, when she recognized her mother. No return of convulsions. Urine drawn, oz. vi, making oz. xiii for the 24 hours. Foxglove poultices ordered over region of the kidneys. In the afternoon became greatly distended. Salts and glycerin enemas given with good results of feces and gas. Verat. vir. θ and salines continued. Sept. 10th, temperature, 99 $\frac{4}{5}$ °; respiration, 28; pulse, 100. During night convulsions returned. Wildly excited, threw herself out of bed. Conscious of things going on about her this morning, although she does not speak. Urine, oz. xv; no change in its pathological constituents. Sept. 11th, 6 A.M., temperature, 102°; pulse, 106; respiration, 25. Rational, but crying and moaning. Bromide and chloral again given. 10 A.M., vomiting; stupid and greatly distended; distention not relieved by enemas. Convulsions returned at 11 A.M., followed by stupor, death resulting at 1 P.M.

CASE II.—Italian; age, 26; ninth month of gestation. Admitted Dec. 13, 1901, in comatose state. Husband states she had been in excellent health up to present time. In the morning she complained of being dizzy, so he took her out in the air for exercise. While walking she was taken with a convulsion, and before he could make arrangements to bring her to the hospital she had three more severe ones.

On arriving she was immediately put on obstetrical table. Examination revealed that labor had begun, the cervix permitting the introduction of three fingers. During the examination she had two more eclamptic seizures, and it was deemed advisable to hasten delivery. The cervix was soon fully dilated manually, the forceps applied, and she gave birth to a still-born babe at 4.50 P.M. Free post-partum hæmorrhage followed, which was easily controlled by a hot sterile water intra-uterine douche. A catheterized sample of urine, previously obtained, gave the following result: Albumin, solid precipitate, sp. gr. 1.006; urea, .007. After being put to bed she slowly regained consciousness, and complained of severe headache and pain across the abdomen. Verat. vir. θ in three-drop doses ordered every 2 hours. She was encouraged to take six ounces of Poland water every hour, and was given saline enemas every three hours. During the night she voided 56 ounces of urine.

Urine showed only a trace of albumin, sp. gr. 1018; urea, .016. Improvement rapidly continued; headache and abdominal distress soon disappeared; she never had another convulsion, and was discharged in just a week, entirely recovered.

It might be well to state that both these women were private cases, treated by old-school physicians, thus accounting for the same routine treatment—the prescribing of verat. vir. *o*, and of bromide, chloral and strychnine in the first case.

CASE III.—Nativity, Irish; age, 24; eighth month gestation. Admitted Nov. 15, 1901. History of previous gonorrhœal infection; has profuse non-excoriating discharge. Urinary analysis: sp. gr., 1030; no albumin or sugar; urea, .023. Large amount pus corpuscles. *R*: Pulsatilla, 3x; carbolic douches b. i. d. Dec. 3d, urine examined; sp. gr., 1008; two lines of albumin; urea, .005. No casts. Large quantities of pus cells. Amount of urine for 24 hours, 44 oz. Vaginal discharge less profuse. Complained of pain on micturition. *R*. Mer. corr. 3x, Poland water ad. lib. Diet restricted; less nitrogenous food, more milk. Dec. 10th, less vesical irritation and vaginal discharge. Dec. 14th, another examination of urine showed total amount had increased to 70 oz. in 24 hours; sp. gr., 1022; no albumin; urea, .025. Apparently in good condition. Dec. 17th, in labor at 11 P.M. Dec. 18th, after being in labor 17 hours (breech presentation) she delivered a still-born child at 5 P.M. She was taken from the table at 5.45 P.M. and put to bed. At 6.15 she began to act strangely. Spoke in an incoherent manner of strange objects appearing before her eyes; the muscles of her hands, face and arms twitched, and in a few seconds was in general convulsions. During this seizure, which lasted about two minutes, she became greatly cyanosed, and her pulse was hardly perceptible. Hypodermics of whiskey and digitalin were immediately given, and oxygen administered at frequent intervals. In a short time the pulse came up, but it was impossible to arouse her from the coma into which she had fallen. Before a vapor tent could be placed over her, she went into another convulsion less severe than the first. Chloroform was administered during this attack. After the convulsion subsided an enema consisting of one pint of normal salt solution and one ounce of whiskey was given. Pilocarpin $\frac{1}{8}$ gr. by hypo. and a hot wet pack soon produced a

free perspiration. Treatment: Aconite, 3x; Poland water, vi oz. q. hr., foxglove poultices applied to lumbar region, whisky when necessary, saline enemas q. 3 hrs. (A catheterized sample of urine after first convulsion showed the presence of a large amount of albumin.)

Dec. 18th, patient somewhat out of stupor, recognized doctors and nurses. Temperature, 102° ; pulse, 128; respiration, 30; urine by catheter for 24 hours, six ounces; sp. gr., 1030. Test-tube solid with precipitate of albumin; urea, .002. Uric-acid crystals. Hyaline and granular casts. Pus corpuscles and epithelium from bladder and kidneys. Same treatment ordered continued. Diet to consist of four ounces of peptonized milk every 2 hrs. Dec. 19th, decidedly worse. Complete suppression of urine; meteoric distention of abdomen. In deep coma. Pulse, 144, irregular and weak; temperature, 100° ; respiration, 36. Treatment: acon. discontinued; prescribed cup. ars. 2x and dig. θ in alternation q. 2 hrs. Foxglove poultices to be continuously applied over region of kidneys. Milk and Poland water continued. During evening 31 ounces of urine were obtained. Heart very weak during night, had to be stimulated often. Distention partially relieved from time to time by salts and glycerin enemas. Dec. 20th, can be aroused at times. Still badly distended. Bronchitis developed. Marked œdema of face, eyelids and ankles. Frequent vomiting of mouthfuls of a reddish-brown fluid. Excreted 40 ounces of urine in last 12 hours. Had an involuntary defecation. Cuprum ars. discontinued. R. Bry. and apis in alternation. General treatment continued. Dec. 21st, temperature, 98° ; pulse, 104; respiration, 24. Great improvement. Passed comfortable night; slept seven hours. Mind clear. Cough better. Œdema still present. Fetid odor from lochia. Distention less marked. Urinary analysis: sp. gr., 1024; albumin, about three lines; urea, .019. Previous treatment continued, with addition of carbohc douches q. 4 hrs. Dec. 22d, temperature, 101° ; pulse, 120; respiration, 20. Entirely rational. Complains of distress in stomach after nourishment. Urinated to-day for the first. Amount of urine, 72 ounces (24 hours). Œdema less marked. Treatment: Nux substituted for apis; foxglove poultices ordered discontinued. Dec. 23d, improved every way; temperature, 98° ; pulse, 80; respiration, 26;

œdema gone; cough nearly subsided; only a trace of albumin in urine. Liquid peptonoids added to diet. Continued gradually to improve; discharged Dec. 31st, recovered.

Knowing the forcible advent of eclampsia, the severity of its symptoms, and the too-oft fatal results both to mother and child, it behooves us to be most careful in our observations of pregnant women committed to our charge. Never was the old adage "An ounce of prevention is worth a pound of cure" more trite than in the handling of this disease; therefore too much stress cannot be laid upon prophylaxis. The prophylactic treatment consists in keeping the patient in a healthy condition by means of outdoor exercise; wearing of suitable clothing, selection of proper food, and regulation of the bowels and excretory organs of the body. A careful examination of urine should be made at least once a month; better still, every two weeks, for which a specimen (24 hours) should be insisted upon. The detection of albumin alone is not of any special pathological significance, as it occurs normally in from 3 to 5 per cent. of pregnant women, and is not found in every case of eclampsia. If, however, there be, in addition, a marked diminution in the excretion of urea and total solids, associated with various nervous and gastric disturbances, such as headache, insomnia, vertigo, sudden blindness, nausea, vomiting, epigastric pain and mental excitement, we recognize a condition of toxæmia, and must direct our treatment towards the speedy elimination of the poison, else convulsions may supervene. In suspicious cases showing symptoms of uræmic poisoning, when the urine is below 1010 in sp. gr. and urea less than 1 per cent., and the total amount of urine less than three pints in 24 hours, the patient should be put to bed on exclusive milk diet. Stimulate the emunctories by means of hot packs, hot tub or vapor baths, saline cathartics, and the ingestion of large quantities of water. Aconite, bell., cup., ars., apis, merc. corr., nux vom., rhus tox. and bry. are of great value, according to the symptoms. If, under treatment, no improvement follows, or severe and oft-repeated convulsions arise, labor must be brought to an end.

With the development of eclampsia we are brought face to face with a very grave condition, and unless heroic treatment is employed the disease generally progresses to a rapid and fatal issue. The general measures adopted by the various

schools of medicine do not materially differ in the treatment of puerperal convulsions. Antidotes and eliminative agents are just as important in uræmic toxæmia as in other poisons, and should be used by the intelligent physician regardless of creed or dogma. During eclamptic seizures, give chloroform. *Veratrum viride*, when indicated by tumultuous heart, rapid, strong pulse and high fever, is followed by most gratifying results. It is the sheet-anchor of the old school, and much lauded in all their text-books; but they fail to realize, when success follows its administration, that they have prescribed it in accordance with the law of similars. It should be given hypodermatically, from 5 to 15 drops of the tincture, to get the most favorable results. *Cuprum ars.* 2x is highly recommended by Goodno and others as a cure for convulsions. In the third case reported, not a convulsion returned after it was given. Not only does it have an effect upon the convulsions, but it also increases the flow of urine.

For the cerebral hyperæmia accompanying eclamptic seizures, aconite, bell., hyos., stram., cicuta, gels. and apis are useful as indicated. If we are unable to control the convulsions by the apparently indicated remedy, chloral, bromide of soda and morphine may be tried, but cautiously, as they are apt to prolong the post-eclamptic coma. When the pulse becomes weak, oxygen, whiskey and digitalis are our most valuable stimulants. *Strychnia*, on account of its irritant action on nerve tissue, is contra-indicated, although it is universally prescribed by the old school. Attenuation and elimination of the poison is best accomplished by the administration of large quantities of water by mouth and rectum, by catharsis, venesection, and free evaporation from the skin. Active purgation is needed. Epsom salts, croton oil and elaterium are usually soon followed by watery stools. For sweating, I believe the hot pack to be the most reliable, as the shock is not so great and better opportunity is given to watch the heart than when hot-air and tub-baths are given. I recall the case of a young girl suffering with the eclampsia of Bright's disease, who immediately went into a state of coma and died after being put into a hot tub-bath, where, previously she had borne well a number of hot packs. *Pilocarpin*, in doses from $\frac{1}{8}$ to $\frac{1}{4}$ gr. (by hypo.), acts well in cases where there are no symptoms of pulmonary

œdema. Blood-letting is advocated by many where there is danger of apoplexy from high arterial pressure. Its efficacy is greatly enhanced by infusions of normal salt solution. In my second case, the post-partum hæmorrhage was undoubtedly of benefit, especially when replaced by saline enemias. Epistaxis, frequently observed in eclamptic women, shows that nature is trying to throw off the poison by opening an avenue of escape for the toxic blood. In this connection it should not be forgotten that aconite is an internal bleeder and is worthy of a trial.

Where the urine is greatly diminished and suppression is threatened, such drugs as ars., apis, apocynum and digitalis are to be considered. Dry cupping, followed by hot fomentations, is advised; but nothing exceeds the action of foxglove poultices in promoting diuresis. The good results obtained by a thorough trial of these poultices at the Rochester Homœopathic Hospital lead to their application in all cases of renal insufficiency treated there.

When we consider the mortality of puerperal eclampsia—30 per cent in mother, 50 per cent. in child—and know that cases recover without any aid whatever, we cannot help but realize how powerless medical science is to combat this virulent and overwhelming disease. Not until its etiology and pathology are more definitely known can we look for much better results.

PULMONARY TUBERCULOSIS IN CHILDREN.

BY C. SIGMUND RAUE, M.D., PHILADELPHIA,

Visiting Physician to Children's Homœopathic Hospital, Philadelphia.

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TUBERCULOSIS of the lungs during childhood manifests itself in a variety of forms, each depending upon the nature of the pathological findings for its clinical characteristics. Furthermore, it may be a primary or a secondary condition, and assume either an acute or a chronic course. The different varieties are: 1. Miliary Tuberculosis; 2. Caseous Pulmonary Tuberculosis; 3. Fibro-Caseous, or Chronic Pulmonary Tuberculosis. A fourth variety frequently encountered in adults, namely,

fibroid tuberculosis of the lungs, is so rare during childhood that it need not be separately considered.

1. *Miliary Tuberculosis*.—Diffuse miliary tuberculosis of the lungs may occur primarily, in which case it runs the course of general tuberculosis described as the “pulmonary type.” In these cases the bacillus gains entrance into the lungs either through the bronchial glands or by means of the general circulation. In the latter instance the infection arises from a local focus in some other portion of the body, *e. g.*, a tuberculous joint affection. It may also be the terminal event of a chronic pulmonary tuberculosis, as a result of the discharge of the contents of a broken-down caseous mass into a blood-vessel, usually a branch of the pulmonary vein (Weigert). The form arising from bronchial-gland-infection is the type encountered during infancy. It is hardly probable that pulmonary infection through the lymphatic system from a primary tuberculous lesion in the intestines ever takes place.

2. *Caseous Pulmonary Tuberculosis* (Fowler), also described as *acute and sub-acute pneumonic phthisis* (“galloping consumption”), is the form of pulmonary tuberculosis belonging to the period of childhood, in contradistinction to the infantile form described above. It is much more common than the chronic form, which, indeed, is rare in young children. Frequently it is engrafted upon a broncho-pneumonia, or occurs as a sequel to measles, whooping-cough or influenza. As a predisposing factor the tuberculous diathesis plays a most important rôle, no doubt more so than during infancy, when exposure to infection, either atmospheric or through the food, is liable to result in the development of the disease even in a healthy babe. Any illness capable of undermining the health and lowering the child's resisting power will also predispose to tuberculosis, even in the absence of a tuberculous family history.

The *pathological changes* in the lungs are either a diffuse pneumonic process which represents the lobar type, and is rare, or a disseminated process representing the broncho-pneumonic type. This is the one usually encountered. We find isolated areas of consolidation, generally in the apical region, but not so strictly confined here as in adults. Usually both lungs are affected throughout, the bases sharing in the pathological process. The consolidation is the result of the epithelial infiltra-

tion of the alveoli, and spreads from a terminal bronchus into the adjoining pulmonary parenchyma by contiguity of structure. Bronchitis and peri-bronchitis are associated with this process. The solid areas undergo caseation, which terminates in cavity formation if the case continue a sufficient length of time. Softening and excavation are the result of secondary infection with the streptococcus or staphylococcus (Prudden). The fever accompanying this process is one of septic intoxication.

Tuberculous pneumonia begins with high fever, as an ordinary broncho-pneumonia, together with the development of signs of infiltration of the lung structure. Physical examination will demonstrate areas of consolidation, usually the apices and bases. The percussion note loses its resonance and assumes a tympanitic quality over these areas, while auscultation reveals loud, moist and sonorous râles, accompanied by bronchial breathing.

The *temperature* range is high and remitting in character. As softening of the pneumonic deposits sets in and the vital powers fail, the temperature may fall to sub-normal in the early morning hours, rising above 102° in the evening. Profuse sweating usually accompanies the fall in the temperature, and during the fever the skin is hot and dry and the cheeks flushed (*hectic fever*).

The *pulse* is weak and rapid, varying from 140 to 160 beats. Breathing becomes rapid and labored, often rising to 60 respirations per minute during the acme of the fever.

Cough remains troublesome throughout, at times being uncontrollable. Emaciation and anæmia develop rapidly, the child becoming pale and haggard, its countenance wearing an expression of great distress. Expectoration is usually scanty in the beginning, but toward the end it may become profuse, changing from mucus to muco-pus. Hæmoptysis may occur. The expectoration gives evidence of *Koch's bacillus*, and will frequently contain fibres of connective tissue, beside pus corpuscles and epithelial *débris*.

The course is rapid and generally fatal. Intermissions may occur, during which the disease remains quiescent for a short time, but it seldom fails to relight and terminate in a fatal issue. Instead of signs of resolution appearing at the end of

a week or two, as in an ordinary broncho-pneumonia, or a crisis at the end of a week, as in a lobar pneumonia, the disease steadily progresses, and the vital forces gradually fail. Death may occur within a period of two or three weeks from the beginning of the attack, or, owing to periods of temporary cessation of symptoms, be protracted beyond that time. A complete *arrest* of the process may take place, but it is seldom permanent; and, after several such remissions, the child succumbs in a few months.

Gastro-intestinal disturbances are present and hasten the decline. Diarrhœa is the most prominent of these.

The *circulation* gradually fails, and respiratory embarrassment advances. The extremities are cold, and enlarged capillaries may show prominently on the chest, even on the cheeks and hands, indicating pulmonary obstruction. A general œdema may set in toward the last, which usually disappears just prior to death.

Infection of the abdominal viscera may occur as a complication, especially if the case becomes protracted; a tuberculous meningitis may arise in like manner.

The *prognosis* is most unfavorable. It cannot be denied that occasionally, but very rarely, we encounter cases presenting every evidence of pneumonia of tuberculous origin that recover, or at least in which the disease is temporarily arrested. Even when evidence of a complicating meningitis is present this may occur. Such a case is reported by Baginsky (*Berlin, Klin. Wochenschr.*, 1881, No. 20), and I have personally seen cases that apparently presented this complication get well; but the prognosis must always be guarded. Fowler ("Diseases of the Lungs," Fowler and Goodlee) expresses himself on this topic as follows: "The prognosis is in all cases unfavorable, but not so grave in the broncho-pneumonic as in the lobar form. In the less acute cases it may fairly be hoped that the disease pass into a sub-acute or chronic form."

A broncho-pneumonia in a child running a protracted course, giving no evidences of resolution, but rather those of destruction of lung-tissue, with hectic fever, should always arouse suspicion of tuberculosis. Likewise a lobar pneumonia running on without a crisis, but going into the above state, providing empyema be excluded, is of grave significance. This form,

however, is rare, although I believe extensive consolidations are more commonly encountered in children than in adults. A clear family history of tuberculosis and the tuberculous diathesis, or a history of prolonged exposure to a tuberculous source of infection, offer strong presumptive evidence.

Positive evidence is offered by finding the bacillus of Koch in the sputum, with possibly fibres of elastic tissue. This diagnostic sign is, however, not always available, owing to the difficulty of obtaining the sputum.

The character of the fever is in itself a strong evidence of the nature of the disease, and when taken in conjunction with the rapid emaciation and prostration, anæmia, diarrhœa, and sweats, the case becomes quite clear.

From this it will be seen that an ordinary broncho-pneumonia should not be confused with caseous pulmonary tuberculosis. A *diffuse broncho-pneumonia* attended by *acute dilatation of the bronchi*, however, may give rise to physical signs indistinguishable, for a time, from disseminated caseous tuberculosis, and we should therefore be cautious in giving a positive opinion (Fowler).

The *physical signs* are those of either a disseminated broncho-pneumonia or of a lobar pneumonia. In the former, scattered areas of dullness, the note assuming a tympanitic quality, can be demonstrated, especially at the apices and the bases of the lungs, bilaterally distributed. The signs of bronchitis will be added; *i.e.*, large and small moist râles. The râles are at first bubbling in character, later assuming a crackling sound. Over the consolidated areas bronchial breathing may be elicited; rarely typical tubular breathing. Signs are not well marked, as a rule, on account of the large amount of secretion which clogs up the bronchi.

In the lobar form all the evidences of consolidation of an extensive area of lung-tissue will be found.

The *treatment* is that of pneumonia. When the fever runs high, cold sponge-baths every two to three hours are of decided benefit. Food should be given at regular intervals, and in the form of liquids or semi-solids of the highest nutritive value. Milk; egg-nog; broths into which a raw egg has been stirred, or strained vegetable broth and raw-meat juice are most suitable. Alcoholic stimulation cannot be dispensed with; the av-

erage quantity will be about a drachm every hour, during periods of adynamia. It not only sustains the strength of the patient, but possesses some food-value, and assists in controlling the cough.

A warm, moist atmosphere is to be maintained, together with the most thorough ventilation. The spraying of hydrogen dioxid about the room is advantageous. When the cough becomes tight and suffocative in character, a cold pack about the chest is of great benefit.

Remedies may be divided into two classes, namely, those calculated to affect the tuberculous process directly, and those useful for special symptoms, such as cough, pyrexia, etc. To the first class belong notably the iodides, especially the iodide of arsenic, and iodoform, calc. carb. and phos., sulphur, tuberculinum. Kreasote is much used for its antiseptic action, but may do harm by upsetting the stomach. Remedies of the second class are chininum arsenicosum and baptisia for the pyrexia; silicea and hyoseyamus for the profuse sweats; apomorphia, tartar emetic, hyoseyamus, phosphorus and lycopodium for the respiratory symptoms.

Some of these remedies combine, so to speak, both offices—for example, the iodide of arsenic. It is not only a constitutional remedy, but at the same time exerts a potent influence over the pyrexia and the catarrhal symptoms. Likewise, one of the calcareas may fulfill every requirement if decided constitutional indications are present, the carbonate suiting the fat, pot-bellied, scrofulous child best; while a poorly-developed, backward child, with flabby abdomen, lax-joints and weak limbs, adenoid vegetations and enlarged tonsils, is more benefited by the phosphate.

Avian tuberculin is recommended by Cartier for bronchopneumonia following one of the infectious fevers and assuming a "suspicious" type. The cough is incessant and tickling in character, the pulmonary symptoms become localized, emaciation sets in, and tuberculosis may be anticipated.

3. *Fibro-Caseous, or Chronic Pulmonary Tuberculosis*.—The chronic form of pulmonary tuberculosis, in which fibrosis is added to the caseous process, is seldom encountered before the sixth year, not becoming a common disease until the time of puberty. No doubt most children showing a decided predis-

position to tuberculosis succumb to either the acute pulmonary form or to general tuberculosis before this period. It may, however, be said that among the colored race it is not uncommon, while the Jews seem more or less immune. Its course is identical with that of cases of consumption in young adults in children above six years. Under this age it may be less typical, the regular hectic fever so characteristic in adults and the classical night-sweats being absent. Indeed, extensive destruction of pulmonary tissue may take place in association with a moderately high temperature without marked remissions or sweating.

A variety of lesions is found, the characteristic and most constant changes being caseation and fibrosis in conjunction with cavity formation. Owing to the tendency to destruction and excavation of pulmonary tissue, the term "ulcerative phthisis" is often applied to this disease. The coexistence of miliary granulations and areas of caseation indicate that the course has been marked by periods during which the pathological process has been active. Such a period of activity often occurs immediately before the death of the patient, and during its continuance miliary tubercles in great number may form in parts of the lungs hitherto unaffected (Fowler).

The seat of the primary lesion is one of the apices, and in the majority of cases the right. The process does not begin at the extreme apex of the lung, but about an inch below that point, and nearer the posterior and external than the anterior border, spreading thence backwards. The upper and posterior part of the lower lobe become primarily diseased often long before extensive infiltration or destruction of the upper lobe has taken place, and, as a rule, before the apex of the opposite lung is attacked. Infiltration of the lung at this site, together with infiltration of the apex, is almost positive proof of the existence of tuberculous disease of the lungs (Fowler).

Associated lesions usually found are bronchitis, peri-bronchitis and bronchiectasis; emphysema (compensatory); pulmonary collapse, the result of bronchial obstruction; œdema and congestion at the bases; pleurisy, usually chronic fibrous, although acute pleurisy with exudation is by no means an infrequent complication of phthisis. Lesions in other organs that may be encountered are tuberculous ulceration of the in-

testines; amyloid disease of the internal organs; tuberculous adenitis; meningitis, and tuberculous arthritis.

Females seem more prone to consumption than males. The ages between 20 and 30 furnish the highest percentage of cases, the number gradually increasing from the fifth year to that time.

Certain previous diseases invite it. An attack of acute pleurisy often precedes the outbreak of pulmonary tuberculosis, or a lung impaired by a former pleurisy may become susceptible. Bronchitis may pave the way, but, according to Fowler, its importance is over-estimated. The same holds good of pneumonia.

Valvular disease of the heart bears an important relation to pulmonary tuberculosis. Congenital stenosis of the pulmonary orifice offers a strong predisposition. Mitral stenosis is not uncommonly found associated with consumption; an observation to which I can add my testimony. The antagonism between mitral disease, particularly regurgitation, and consumption, taught by Louis, is not absolute. Fowler has observed a number of cases in which the diseases co-existed, and others have collected a sufficient number to disprove the theory.

Syphilis may predispose to tuberculosis by lowering the resisting power of the organism. It is even claimed, by Hochsinger, that both the virus of syphilis and tuberculosis may be transmitted to the offspring by the parent at the same time.

The only evidence of the disease to attract attention in the beginning may be *emaciation*, with gradually failing health. *Cough* is usually slight, and of a dry, hacking character, or there may be an associated bronchitis, with free expectoration. In some cases, recurring attacks of acute bronchitis precede the pulmonary involvement; in others, infiltration of the lungs advances steadily in the absence of all catarrhal manifestations.

Hæmoptysis may be the first symptom to arouse suspicion. Even in young children it is frequently observed (Baginsky), usually auguring a rapid course. Hæmoptysis does not, however, always indicate destruction of pulmonary tissue; to the contrary, it is usually an early symptom, indicating merely high tension, and engorgement of the pulmonary and bronchial

blood-vessels. Chest pains are due to either localized pleurisy, myalgia, or intercostal neuralgia, and are generally persistent.

Physical examination reveals an emaciated frame; long, flat chest, and superficial, feeble respiratory movement in typical cases. The absence of the true paralytic thorax does not, however, exclude the possibility of pulmonary disease by any means. When the process is active, the skin is dry and feverish. Commonly, enlarged superficial lymphatic glands can be felt in various regions of the body. The clavicle stands out prominently, as do also the angles of the scapulæ, and the infra-scapular region is flattened. Palpation reveals increased vocal fremitus in either one or both infra-clavicular regions; the percussion note is dull in the supra-clavicular region, and the area of dullness often extends down as far as the third rib anteriorly and posteriorly, occupying the inter-scapular space on one or both sides of the spinal column. The dullness may be associated with a suggestion of tympanitic quality. Auscultation reveals, in the early stages, harsh breathing in the affected apex, associated with fine, crackling râles. Broncho-vesicular breathing soon develops. As infiltration advances, bronchial breathing can be elicited in the infra-clavicular space. The first place this can usually be demonstrated posteriorly is at a point opposite the fifth dorsal spine, midway between the border of the scapula and the spinous processes of the vertebræ (Fowler). As softening and excavation occur, the signs of cavity are added.

Fever is an indication of the activity of the process. When not exceeding 100.4° F. it may be considered purely of tuberculous origin; when higher, it is due to secondary infection, and usually betrays its septic character by marked remissions (Koch). Periods of latency may occur, during which there is no pyrexia, although the pulse, as a rule, is weak and rapid throughout the entire course of the disease. As characteristic of the tuberculous pulse, it is claimed that the number of beats per minute is not influenced by reclining or standing, as occurs normally.

The morning temperature is frequently subnormal, even during periods of quiescence. With infiltration and beginning softening, the evening temperature rises to 100° to 100.5° F. Secondary infection and rapid disintegration of lung-tissue are

accompanied by a higher evening rise, the fever assuming the hectic type. At times, extreme fluctuations in temperature occur without causing much distress to the patient. Fowler is of the opinion that high fever may be present without septic infection, simply indicating a rapid progress of the disease in an organism still capable of reaction. This, however, seems unsound, in the face of the researches of Koch and Prudden. Paroxysms of high fever, followed by sweating, invariably indicate an admixture of septic intoxication. *Night-sweats* are a common and most distressing symptom; ordinarily they simply indicate exhaustion, occurring as the temperature falls to normal or sub-normal.

The *alimentary tract* becomes deranged, and anorexia and diarrhœa are common complications. The latter symptom, occurring at the termination of the disease, indicates intestinal ulceration. Vomiting may be a troublesome symptom, resulting either from severe coughing paroxysms or gastritis.

Albuminuria is more common in children than in adults (Baginsky).

In rapidly progressing cases a distressing cough, with free expectoration of yellowish, lumpy muco-pus containing the bacillus in large numbers, will be found. Hæmoptysis is generally associated with such cases.

Chronic fibroid phthisis may be encountered in children, but it is rarer than the above variety. In these cases there is usually a dry, harassing cough and less pyrexia, while, pathologically, fibrosis is in excess of the infiltrative process. The course is slower than that of fibro-caseous tuberculosis, but in the majority of cases an acute tuberculous complication brings on a fatal termination (Baginsky).

The prognosis is unfavorable, especially when the disease develops at the period of puberty—a time when the organism requires every spark of vitality for its growth and development, and at which there is the strain of school life to be considered. In girls, the tendency to chlorosis is also an unfavorable event. In younger children, if the course be not an acute one, the prognosis is more favorable, but still grave. Cases have no doubt been checked, but it is impossible to foretell a relapse or a later complication, such as meningitis, setting in. If arrest in the stage of infiltration can be accomplished, the prognosis is

good. The constitution and family history must also be taken into consideration in forming an opinion as to prognosis. As Duckworth puts it, we do not cure our tuberculous patient; all that we can do is to place him in conditions favoring an arrest of the progress.

A positive *diagnosis* is based upon a demonstration of the physical signs of infiltration and destruction of lung-tissue described above, the character of the fever, and the discovery of the *bacillus of Koch*. A combination of any two of these data affords the strongest presumptive evidence of the existence of phthisis. Early in the disease, however, at which time it is most important that the malady be recognized, it is not always possible to find unmistakable evidence of tuberculosis; and especially in children are we at a great disadvantage, owing to the difficulty of obtaining sputum for microscopical examination. Cough and emaciation, however, in a child with a tuberculous family history, or the history of having been exposed to such infection, together with slight evening pyrexia, should lead to a most thorough examination of the chest. The finding of a few localized sub-crepitant râles at the apex of the lung, together with a prolonged expiratory sound in such a case, will enable us to make a diagnosis of beginning pulmonary tuberculosis. Later, as the classical symptoms of the disease develop, the diagnosis is comparatively easy. *Chronic purulent bronchitis* is, perhaps, the most frequent condition we are called upon to differentiate; but here the absence of the bacillus and the negative condition of the lungs will exclude tuberculosis.

In the *treatment*, prophylaxis is of first importance. Children presenting a tuberculous family history are liable to succumb to pulmonary tuberculosis on account of an inherited constitutional weakness. This predisposition is not, however, confined to such alone, as any constitutional enfeeblement in which the resistance of the organism is sub-normal, especially when the chest is underdeveloped, offers a predisposing factor. Such children should be brought up in a locality where fresh air in abundance can be enjoyed, and they should be encouraged to lead an out-of-door life rather than be urged on in their studies. Particular stress should be laid on the physical development of the chest by suitable and methodically-carried-out breathing-exercises and calisthenics; and for overcoming the cold-catch-

ing tendency, a cold sponge-bath, followed by brisk rubbing with a coarse towel, is most efficacious.

A careful inspection of the nose and throat should be instituted early, to determine the presence of local pathological conditions that may interfere with the proper performance of the function of respiration. The importance of early recognizing adenoid vegetations or enlarged tonsils, and promptly removing them by appropriate means, cannot be overestimated. And, lastly, it must be accepted as a fact beyond dispute that the most important prophylactic factor is the avoidance of giving entrance to the *bacillus of Koch* into the system. The infant's food should, therefore, be sterilized, unless it is positively known to be free from contamination. Nor must it be brought up in an environment menaced by the presence of a consumptive. The same holds good with older children. Until more rigorous sanitary measures are enforced, and the consumptive is educated to dispose of his expectoration in a safe manner, and avoid too intimate relations with those about him, the disease will not decrease very materially.

When the disease has become established, it behooves us to decide whether the patient is to be cared for at home or sent to a more suitable climate. It is worse than useless to send away a patient whose condition is an acute one, or in whose lungs advanced destructive changes have already occurred, and pronounced emaciation, fever and night-sweats exist. On the other hand, a timely change of *climate* has saved many a life, especially if the patient can pursue an out-door life. The requirements of a suitable climate are pure, uncontaminated air, equable temperature, and a maximum amount of sunshine. High altitude is by no means necessary; it best suits cases in which the disease is limited and there are no cavities. It may prove disadvantageous to some cases by bringing on dilatation of the air-vesicles on account of the rarified state of the air, thus making it impossible for the patient to return to a low region. Hæmoptysis also contra-indicates a high altitude, and neurotic temperaments are aggravated thereby. A moderate altitude is preferable in most cases. The most suitable locations offering this natural advantage are the Adirondacks, the Southern pine regions, and the great plains bordering the Rocky Mountains. A location at sea-level seems better for

chronic cases with emphysema, especially when there is nervous irritability, insomnia, and loss of appetite. It is also beneficial in septic pyrexias. Many consumptives do not mind cold weather; in fact it benefits them. For such, the Adirondacks and Denver, Col., are good locations. Others, again, especially those in whom there is considerable bronchitis, are required to seek a warm, moist climate, especially in winter. Florida, the coast region of Southern California, and the Bermudas, offer these advantages. The main feature of climatic treatment, however, is the out-door life invited thereby. Perhaps no form of treatment has yet given the promising results obtained in the sanatoria in which *open-air treatment* is systematically carried out, combined with hydro-therapy and judicious exercise.

When it is impossible to send the patient away from home, he should receive all the benefits of the *open-air treatment*. When he is able to be out, he should enjoy every hour of sunshine available. If he is too weak to walk, or if there is fever, he should sit in the sun, well protected with sufficient clothing, and screened from draughts. In winter, as well as in summer, the windows of the sick-room should be kept open. During the night the sleeping-chamber must be kept thoroughly ventilated, there being less harm in night-air than in a stuffy atmosphere.

The *diet* is very important. So long as the appetite remains good and diarrhœa is absent, the case should not be despaired of. A change of climate often brings about a restoration of appetite when that has been on the wane, and may in this way alone confer great benefit. It is important to feed the patient as much as he can take; in fact, over-feeding has even proven beneficial in some instances. Osler has seen good results following Débove's method of introducing a mixture of milk, egg and finely-powdered meat into the stomach, through a stomach tube, three times daily, in cases in which gastric symptoms were distressing. Raw eggs are especially adapted as a food for the tuberculous. Cod-liver oil is usually well borne by children, and is useful so long as it does not disturb the digestion. Even in the presence of pyrexia not above 100.4° F. we should not refrain from liberal feeding. Alcoholics are useful here particularly when they tend to increase the appetite. Egg-nog is a desirable form in which whisky can be administered. *Raw*

meat is supposed to possess antitoxic properties, and can be administered as balls of chopped meat rolled in pulverized sugar, in which form children will usually take it readily. Personally, I consider it one of the most valuable foods for the tuberculous.

Special Symptoms.—When there is continuous *pyrexia*, or high evening temperature, rest in bed is imperative. Sponging with tepid water to which alcohol has been added exerts a refreshing and tonic influence, beside being a safe means of reducing temperature. The so-called “antipyretics” are positively harmful. Such remedies as *china*, *chininum arsenicum*, *baptisia* and *ferrum phos.* present special indications for their selection in the pyrexia of tuberculosis, and exert a most favorable influence over the same. Full indications will be given later on.

Cough.—A cough which occurs in the morning, and is accompanied by expectoration, is useful, and should not be checked. Expectoration is materially aided by giving the patient a cup of hot milk, to which a teaspoonful of rum has been added, in the morning, on awaking. On the other hand, a cough that continues during the night, causing loss of sleep, must be controlled (Fowler).

The old school employ *codein* for this purpose; but we have among our remedies most efficient means for controlling the cough, with which we do not run the risk of drying up secretions or overcoming reflex irritability to a dangerous degree. I would especially mention *hepar sulph.*, 3x trit., as a most valuable remedy for the teasing night-cough of phthisis. *Drosera* is highly recommended by Hughes (*Manual of Therapeutics*) for cough depending upon increased reflex excitability. Beside these, *hyoscyamus*, *lachesis*, *ipecac* and *corallium rubrum* should be studied. When profuse expectoration is present, *stibium iodide* 2x (Goodno), *arsenicum jod.*, *lycopodium*, *stannum met.* and *calc. carb.* are the remedies most likely to prove useful. They must be carefully differentiated, in order to give the best results.

Hæmoptysis, when slight and associated with tightness across the chest and hoarseness, calls for *phosphorus*. Hughes places phosphorus foremost when the air-passages are much implicated in the morbid process. *Geranium maculatum*, tincture, has proven of great benefit in profuse bloody expectoration.

The inhalation of *kreasote*, a few drops in a mixture of alco-

hol and chloroform, is often efficient in allaying an irritating cough, and in improving the character of the expectoration when it becomes offensive.

Night-sweats are often uncontrollable, and try the physician's skill to the utmost. I cannot see the feasibility of using extreme measures to check the same, as the sweating is only a sign of exhaustion when it occurs during sleep, or the natural termination of the febrile movement when it occurs at the decline of the fever. Our aim should be to build up the patient, and, if necessary, we may administer a stimulant at bedtime. When due to fever, a tepid or cold sponge-bath at bedtime is beneficial. *China* tincture is a good remedy in these cases, owing to its tonic properties. *Silicea*, 6x trit., acts most satisfactorily when there is pulmonary disintegration. I have seen an iron tonic gradually relieve the condition where the routine old school treatment had been used without success. Hughes recommends *iodine* for nocturnal sweats. *Phosphoric acid* 3x will do a great deal for the debility resulting from sweats, diarrhœa and bronchorrhœa. *Jaborandi* is homœopathic to profuse sweating, and has given good results. Goodno recommends *agaricin* 1x, one grain at bedtime. *Atropin* is the stand-by of the old school.

Diarrhœa, when due to catarrh of the bowels, can be controlled by restricting the diet to semi-solids and selecting the proper remedy. *Phosphoric acid* is the most important. When there is tuberculous ulceration of the bowel, slight hope for improvement is offered. This is the form encountered as a terminal stage of the disease. *Arsenic* may benefit this condition and should be given a trial.

Gastric disorders may result from over-feeding. The best evidence of this is the presence of undigested food-particles in the stools (Fowler). When there is purely a gastric incompetency, *nux vomica* proves of great value. A catarrhal condition will call for such remedies as *pulsatilla*, *hydrastis* and *ipecac*. *Kreasote* is indicated when there is vomiting of glairy mucus, usually in the morning. It is a favorite remedy of the old school to improve the digestive function, increasing the appetite and checking flatulency.

Laryngeal symptoms supervening during the course of phthisis are mostly catarrhal in nature. *Spongia* is the chief remedy

(Hughes). Tuberculous laryngitis requires the attention of a specialist.

The following list of remedies, with their clinical indications, may be studied for a fuller knowledge of the therapeutics of phthisis :

Aconite.—Pleuritic stitches, and blood-spitting after taking cold. *Ferrum phos.* is similar, but under this remedy there is less circulatory excitement and anæmia, and vasomotor disturbances are pronounced.

Arsen. alb.—Dyspnœa from exertion; cough between 1 A.M. and 3 A.M. Fever-heat and chilliness intermixed. Restlessness and thirst for small quantities of water. There is prostration and emaciation; anæmia and œdema of ankles; terminal diarrhœa. Mostly indicated in the *pneumonic type*.

Arsen. iod., 3x trit., freshly prepared. Well suited to *fibro-caseous form* of the disease when there is profuse purulent expectoration; emaciation; hectic fever and prostration. *Stibium iodide*, 2x trit., is highly recommended by Goodno in cases presenting profuse muco-purulent expectoration. *Stannum iodide* has profuse purulent expectoration easily raised, and of sweetish taste. It is more useful in chronic bronchitis.

Baptisia.—Chill in forenoon or afternoon, followed by heat and perspiration; general weakness and languor. *Baptisia* is one of the best remedies for the pyrexia of phthisis, and has been extensively used since it was recommended by Dr. J. S. Mitchell. It is usually employed in the tincture and lower dilutions.

Bryonia.—Cutting pleuritic pain when taking a deep breath or coughing. Dry, deep cough, the irritation starting from the epigastric region.

Calc. carb.—"Pre-tubercular stage" in strumous subjects, the characteristic features being a form of indigestion associated with acid eructations and difficulty in assimilating fats (Hughes). Pale, rapidly-growing youths (*phos. acid*) or scrofulous children are especially benefited by this remedy. In the later stages it is indicated by tendency to perspire on slightest exertion; damp, cold feet; shortness of breath on ascending stairs; expectoration consisting of mucus with an admixture of pus which sinks in water, leaving the frothy mucus floating above.

Carbo veg.—Flatulent dyspepsia and chronic hoarseness.

China.—Septic fever, consisting of a chill, followed by high fever and sweat, usually occurring at regular intervals. Anorexia; chronic diarrhœa. Tincture and lower dilutions.

The *arsenate of quinine*, 3x trit., is better indicated when the pyrexia is more irregular, especially if arsenic symptoms are present.

Ferrum phos.—Fever in the early stages, before septic infection has set in. Hæmoptysis in the early stages not dependent upon excavation of lung-structure.

Hepar sulph., 3x trit., two grains every hour at night until cough is relieved. The cough is due to a persistent irritation in larynx, not relieved by free expectoration. It is excited by uncovering any part of the body, or by contact of body with cool bedclothes on first retiring. There is usually slight hoarseness, with rattling of mucus in larynx, but, as before stated, expectoration does not relieve the symptoms. *Drosera* has a deep, spasmodic cough presenting this element of hyperæsthesia, but there is not the free secretion present in *hepar*. *Hyoscyamus* has symptoms of cough worse on lying down at night; dry, spasmodic and titillating in character.

Iodine.—This remedy also presents characteristic cough symptoms. "Constant tickling in the windpipe and under the sternum, with expectoration of a transparent mucus, sometimes streaked with blood. Morbid hunger, even soon after a meal, and yet loss of flesh. Dark hair and eyes" (C. G. R.).

Kali carb.—Sharp stitches in chest; cough worse 3 A.M.; puffiness of upper eyelids and swelling of ankles.

Lachesis.—Cough during sleep without awaking the patient; chilliness, followed by fever, with great talkativeness; sensation of suffocation; fluttering of heart; offensive stools.

Lycop.—Expectoration of large quantities of pus after neglected pneumonia (C. G. R.). Cough day and night, the expectoration tasting salty. Hectic fever, with circumscribed redness of cheeks, usually late in afternoon (4 P.M. to 8 P.M., aggravation of symptoms). During the fever we often observe automatic fan-like movements of the *alæ nasi*, not due to dyspnœa, but sympathetic with the pulmonary disturbance. "It suits cases of a chronic and passive character, and is, I think, especially useful when phthisis occurs in young men." (Hughes).

Nux vom.—Digestive derangements, and aggravation of cough-symptoms from over-eating. *Kreasotum* 2x is one of the best remedies for persistent vomiting in phthisis.

Phosphorus.—Tormenting cough, often with hoarseness; worse toward midnight; tight and painful. There is tightness across upper portion of chest; inability to lie on left side; gastric irritability and diarrhœa or constipation, with long, thin stools. "Cough in the earlier stages of phthisis, with unusual implication of the air-passages in the morbid process" (Hughes).

Phosphoric acid, 3x dil., acts restoratively when the system has been drained by long-continued diarrhœa or persistent night-sweats.

Sulphur.—Delayed resolution after pneumonia; chronic catarrhal deposits at apices, with a few moist râles. Neurasthenic individuals. Weak, gone feeling at 11 A.M., with craving for food or a stimulant. Vaso-motor disturbances.

Iodoform, 3x trit.—A one-grain tablet four times daily has given me most promising results in incipient cases of fibro-caseous pulmonary tuberculosis, and I use it in preference to the other iodides in the stage of infiltration.

Tuberculin (Koch) has been successfully employed in broncho-pneumonia, and is considered by Arnulphy capable of stopping the progress of incipient cases of tuberculosis of the lungs in a large proportion of cases (*Clinique*, June, 1897). *Avian tuberculin* is recommended by Cartier for suspicious broncho-pneumonia. These nosodes have usually been given in the higher dilutions, either the 30th or 100th, although Mersch obtained his results from the 6th.

GRANATUM IN PERSISTENT VERTIGO.—Dr. Clarke, the editor of the new Dictionary of Materia Medica, calls attention to the observation of Dr. Colby, who has noticed that patients after taking granatum or pelletierne, as a tæniicide, were obliged to lie down for one or two hours on account of the distressing vertigo which these drugs produce. Acting upon this hint, he prescribed granatum in several cases of persistent vertigo. His results were excellent. One of his patients had auditory phenomena well marked; one had tinnitus and diminished bony transmission; two had symptoms of cerebellar disturbance. It would seem, then, that the indication "persistent vertigo, better lying down, with or without aural symptoms," is a reliable clinical symptom for granatum.—*Hom. World*.

THE EYE LESIONS CONSEQUENT UPON MEASLES.

BY CHARLES H. HELFRICH, M.D., NEW YORK,

Surgeon, New York Ophthalmic Hospital, New York.

(Read before the New York State Homœopathic Medical Society, Feb., 1902.)

MEASLES has such a strong affinity for the structures of the eye, and is so frequently attended by ocular lesions, that a consideration of the latter may be of mutual interest to the general practitioner and the specialist. Measles may affect all the structures of the eye from the skin covering the lids to the deeper structures, like the optic nerve. Some of them are familiar to the general practitioner—in fact, more familiar to him than to the specialist; but others, especially those most grave in their bearing, are known more commonly to the specialist.

Commencing in anatomical order with the lids, we find the epidermis covered with the rash like other parts of the face, presenting, however, no special features in this situation.

Marginal blepharitis is a common complication. It may occur during the progress of the general trouble, but it is most common later. It is characterized by redness and swelling of the margin of the lids and the formation of little scales or crusts which are very adherent to the cilia, so that efforts to remove them are frequently followed by loss of some of the lashes. While it may occur alone, it is often accompanied by conjunctivitis eczematosa, which will be spoken of later.

It has been observed during convalescence, in some cases of measles, that the meibomian glands, both on the upper and lower lids, become inflamed and suppurating, the pus finding an outlet upon the inner surface of the lid by breaking through the tarsus and conjunctiva. Several such cases have come under my notice.

Every one is familiar with the fact that the mucous membrane of the eyes and nose and the tear passages connecting them is inflamed. It is then easy to appreciate how obstruction of the tear duct and inflammations of the lachrymal sac are sometimes sequels of measles.

Characteristic of measles, and coming on before the appear-

ance of the rash, and even before the pyrexia, is acute conjunctivitis, which manifests itself in the usual way by redness, swelling, lachrymation and photophobia, the latter often intense. The secretion is acrid, causing irritation and swelling of the skin over which it flows, and often producing cracks at the canthi. Conjunctivitis usually increases in severity, attaining its height during the height of the pyrexia, after which it declines and subsides with the general disease. Often, however, it persists for some time subsequent. Unhappily, conjunctivitis does not always follow the benign course just described. Upon rare occasions it assumes the diphtheritic or blenorrhæic type, without ever becoming, however, true diphtheria or blenorrhœa. Naturally, in such cases, the integrity of the cornea is threatened.

In my experience, the most common eye sequel of measles is conjunctivitis eczematosa, or phlyctenularis, as it is more commonly known. It is due to the dyscrasia produced by the general disease. In its most simple form one or more small grayish elevations appear at or near the corneal border, accompanied by a characteristic injection triangular in shape, the apex corresponding in each case to the phlyctenule. There is considerable photophobia and lachrymation. The phlyctenule gradually breaks down, with a slight loss of substance, affecting merely the epithelium, and then heals. Relapses are quite common. The disease is not always so simple, especially in strumous subjects. The acrid lachrymation excoriates the skin of the lids and face, producing scabs, blepharitis and swelling of the lids. At the same time the photophobia becomes so intense that spasm of the lids occurs, and the child shrinks to a darkened corner of the room and buries his face in his hands. It now requires dexterity to separate the lids and inspect the cornea, which must be done daily, notwithstanding, and the efforts to do so frequently cause bleeding of the lids, especially at the canthi, where the skin is cracked. Frequently a mucconjunctivitis is present in addition.

The importance of inspecting the cornea daily cannot be too firmly impressed upon the mind, as ulcers of the cornea often occur. Not only do ulcers of the cornea occur in conjunction with conjunctivitis eczematosa, but they are often found alone. This is especially true of the *ulcus serpens* or abscess, which

appears under the form of a grayish or yellowish disc-shaped opacity at the centre of the cornea, the opacity being greater at the circumference of the disc than at its centre. Surrounding this disc is a delicate gray area, and radiating from it are fine gray striæ which extend into the transparent cornea. The corneal surface corresponding to the disc is dotted, and at first may be raised above the level of the surrounding surface, but soon it shows as a shallow depression. Associated with it is a violent iritis and pus in the anterior chamber. The ulcer extends in a crescentic shape and becomes deeper and deeper, until finally perforation may take place, with escape of the aqueous humor and entanglement of the iris in the opening. The disease may stop at this point or go on to the total destruction of the eye by panophthalmitis.

Even more destructive a sequel is keratomalacia, or softening of the cornea, a disease confined to childhood, fortunately not very common, but sometimes following measles. It first appears as a dryness of the conjunctiva, especially of the part corresponding to the palpebral fissure. Here triangular dry patches are found which are glistening and have an appearance as if they were smeared with grease. The lachrymal gland secretes tears, but they do not moisten these patches. Subsequently the dryness extends over the entire conjunctiva, and over the cornea. The latter becomes cloudy, then disintegrates, and finally breaks down into pus. The prognosis is bad, as in most cases they not only lose their eyes, but their lives.

Like diphtheria, measles sometimes causes paresis of the muscles of accommodation. It is easily recognized by inability to read fine print at the ordinary distance (unless the case is extremely nearsighted), while distant vision is not affected (except in cases of well-marked farsightedness).

Before proceeding to the most interesting of the intraocular disturbances I would mention, in passing, that purulent choroiditis sometimes, though rarely, follows measles, and that it is generally destructive to the sight, as well as to the eyeball itself.

A number of cases of blindness due to neuritis have been reported. A study of them permits of a clinical division in two classes. First, retro-bulbar neuritis, where the ophthalmoscope shows either no eye lesion at all, or only late in the

history of the case; and, second, optic neuritis, where the ophthalmoscope reveals the usual changes in the papilla from the start.

The histories of the cases in the first class seem to indicate that they are due to a lesion of the visual centre in the occipital lobe, because, despite the blindness, the pupillary reflex persists. In one case where a post-mortem was made, though some years after the attack, a lesion was actually found in this situation. If the primary lesion is restricted to the visual centre, however, it will not account for the haziness of the papilla and retina which often appears later. This can only be accounted for by consecutive retro-bulbar neuritis. In the majority of cases the onset was sudden, it was ushered in with head symptoms, and the blindness was pronounced when first recognized. Their subsequent course was followed by recovery in some instances and permanent blindness in the rest.

With reference to the second class, where optic neuritis manifests itself from the start, the opinion is held that they are due to meningitis. Not necessarily meningitis with delirium, fever, opisthotonos, etc., as is ordinarily implied by the term, but a more localized inflammation of the membranes in the vicinity of the chiasm. Cerebral meningitis is so rare a complication of measles that some of the text-books on diseases of children do not mention it. Some of the reported cases of optic neuritis following measles, however, were preceded by a well-marked meningitis, while others apparently had none. The latter cases, however, it is supposed had a localized inflammation of the membranes near the chiasm. The cases of optic neuritis seem relatively more frequent than those of retro-bulbar neuritis, and their histories would seem to indicate that the prognosis is worse.

Optic neuritis can also appear in a more roundabout way. The middle ear suppuration, so frequent after measles, may, by extension of the inflammation to the brain or its membranes, cause optic neuritis.

After saying so many hard things about measles it is a relief to be able to record that it may rarely have a beneficial effect upon the eye, as it has greatly benefited a case of trachoma with pannus.

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DISTURBANCES OF EQUILIBRIUM.

BY ELMER JEFFERSON BISSELL, M.D., ROCHESTER, N. Y.

(Read before the Western New York Homœopathic Medical Society.)

SOME years ago, while reading the "Principles of Psychology," by Herbert Spencer, and a work on "Physiological Psychology" by Prof. Ladd, of Yale University, I was impressed with suggestions of what might be called a muscle sense. The thought occurred to me whether this muscle sense was really distinct and could be separated from the other five senses, or was it a resultant; or, if I may use the term, a co-ordination of the information gathered by the regular five channels of sense impressions. This thought stimulated me to carefully analyze all cases of vertigo coming under my observation, and to closely follow the current literature on the subject. When this symptom, *i.e.*, vertigo, is elicited from the patient, it is ordinarily passed over as of no great significance. If the physician consulted is a homœopath, he may try to determine whether the patient falls forward, backward, or sideways, but he does this usually for the one purpose of fitting a remedy to the case, and not for purpose of locating the excitation of the symptom, nor for learning its essential character and diagnostic value.

If we turn to the text-books on Practice, the explanations given of this symptom are anything but clear and satisfying, and in current literature there are varying, and, at times, conflicting theories presented. In the midst of this confusion I do not presume to set everything in order; but it does seem to

me that some degree of harmony may be secured and many seeming differences cleared away.

As an introduction to this subject, I will quote from the President's address in December, 1900, before the New York Academy of Medicine. The doctor says there are four varieties of vertigo: first, gastric; second, cardio-vascular; third, ocular; fourth, aural. I have seen this classification quoted as though it gave a comprehensive analysis of vertigo; we may, therefore, ask ourselves the question, Why these four varieties and no more? What difference is there between gastric and cardio-vascular vertigo, unless it is simply a difference in location of the excitation; and if there is a difference, is it any greater than in a dozen other varieties? for I find carefully reported cases of nasal, laryngeal, toxæmic, organic, hysterical, epileptic and endemic-paralytic vertigo. The question has, perhaps, already arisen in your mind, May not these other varieties be comprehended in the first four? I think not. The different varieties simply designate the region of excitation, and do not furnish the slightest hint of any peculiarity in the manifestation of the vertigo, nor any clue as to what vertigo really is. When we begin to designate a symptom by the region from which it is produced, then our classification can only be limited by the regions from which it is possible to call it into activity. If, to-morrow, it could be shown that some disturbance in the foot caused vertigo, then there would be as good reason for adding a foot-vertigo to the list.

The main point to be considered is, What essential elements enter into the production of vertigo? As leading to an answer to this question, I believe there are only two forms of vertigo differing not in manner of manifestation, but in method of production:

First, intra-cranial vertigo,

Second, labyrinthine vertigo.

In giving this classification I would not have you infer that the present way of designating vertigo is valueless; on the contrary, I think it is quite helpful in tracing the symptom to the place of its excitation; but if the source of irritation is in the nose or larynx, we must not stop at the four varieties given by the President of the New York Academy of Medicine, for if we do we lose the whole practical value of such a classification.

To return to the two forms which I have suggested, let us see if there are any physiological, pathological or clinical facts to support such a classification.

Intra-cranial Vertigo.

This form is produced by any intra-cranial pathological condition which interferes with the transmitting power of the nerves going to or from the centres of equilibration, or directly excites disturbances in, or involves destruction of, the centers themselves. This form, therefore, might come from tumors, abscesses, hæmorrhages, foreign bodies, nutritive and structural changes of whatever nature within the cranium. Where are these centers of equilibration? Experiments have shown that they are largely within the cerebellum and corpora quadrigemina. Irritation of the anterior part of the middle lobe of the cerebellum causes a tendency to fall forward; irritation of the middle and posterior parts produces a tendency to fall backward; and of the lateral lobes or middle peduncle, a tendency to whirl around. There is a vast amount of clinical and postmortem experience to confirm this. Vertigo in all such cases is a symptom of great diagnostic value, and at times is important as a localizing symptom in intra-cranial disease.

Labyrinthine Vertigo.

The great point at issue is, Are all other cases of vertigo (not included in my first group) directly or indirectly of labyrinthine origin? I believe they are. In support of this, two points must be considered: First, have anatomical and physiological investigations proven any relation between the semicircular canals and the brain centres of equilibration; and have diseases of these semicircular canals confirmed this? Second, if this is affirmatively established, how can remote disturbances, as, for instance, in the stomach or nose, bring about through the labyrinth—which is not diseased—the symptom we call vertigo?

As to the first of these questions, experiments show that irritation of the vertical and horizontal canals and of the vestibule causes vertigo similar in character to that produced by directly stimulating the different parts of the cerebellum, as I have already described; and, what is of still greater significance,

nerve fibres have been traced from the labyrinth to the cerebellum.

Furthermore, anyone can bring on vertigo by pressing in upon the tympanic membrane and suddenly changing the tension on the fluid within the labyrinth. I say "suddenly," for we find at the round window, and, in fact, in the whole chain of ossicles and tympanic membrane, an arrangement to compensate for varying pressure, and soon the normal tension is restored. If it were not for this sort of safety-valve, vertigo would be much more frequent and persistent than it is.

My theory is that, under increased tension of the fluid of the labyrinth, an anæsthesia is produced, much in the manner of what we find in glaucoma. When labyrinthine vertigo, therefore, is present, it is brought about not by an over-stimulation, but by a lack of nerve innervation. If these curiously constructed canals, with the tension of the fluid within so delicately adjusted, are not for some purpose in maintaining our equilibrium, what in the name of anatomy are they for? Surely this is no vermiform-appendix problem, for we do find that disease directly involving these structures causes symptoms in accordance with the above facts.

We come now to the second and last point which I raised, How may remote disturbances bring about through the labyrinth, which is not diseased, the symptom we call vertigo? Again it seems to me that it is produced by variations in the intra-labyrinthine pressure. These variations, which we may designate either plus or minus tension, are caused by abnormal conditions in the middle or external ear; by varying pressure in the cerebro-spinal fluid which directly communicates with the fluid of the labyrinth, or the tension may be influenced directly through the sympathetic or vaso-motor system. Look at this last thought a minute. The blood supply of the labyrinth is from the internal auditory artery, a branch of the vertebral arteries. These receive their nerve supplies from the cervical sympathetic system, which would bring the blood supply of the labyrinth under the influence of a large portion of the body. For instance, we know that the hypogastric nerve is in very close relation with the cervical sympathetic system; does this, then, not explain the gastric and cardiac vertigo, and so on? By this theory I could explain every case of vertigo not included in

the first group. The most difficult cases to harmonize with this theory are the ocular cases, for it is a well-established fact that some corrective and educational influence in maintaining our position and in controlling our power of orientation comes into our possession by our eyes and, to some slight degree, by all our senses. For some time aural specialists have noted the clinical fact that not infrequently, in disease of the labyrinth, there was nystagmus, and even diplopia. Some late experimenters have claimed to have produced strabismus by localized stimulation of the labyrinth.

If this can be confirmed, it shows a very intimate relation between the eye-muscles and the nerves of the labyrinth, and therefore we do not need to resort to a psychical theory for so-called ocular vertigo. In conclusion, then, my contention is that the semicircular canals and labyrinth furnish some influence in maintaining our equilibrium, and that all non-paralytic disturbances of equilibrium not of intra-cranial origin come through these structures, and that in abnormal labyrinthine pressure some disturbed (probably diminished) sensory impulse goes to the nerve centres of equilibration.

HEPAR SULPH. IN ANGEIO-NEUROTIC ŒDEMA.

BY F. F. LAIRD, M.D., LOS ANGELES, CAL.

THE rural matron, being congratulated by one of her cronies upon having a son so far advanced in his college career, replied, "Yes, he's now in his *sycamore* year!" When a young physician recently informed the writer that he had "successfully treated more than five hundred cases of angeio-neurotic œdema," it would seem that the aforesaid medico had scarcely reached even the "sycamore" stage of advancement, since the ear-marks of freshman proclivities were so much in evidence. Lest, therefore, the title of this paper be misconstrued by even the alumni in medicine, Professor Osler's definition of the disease is prefixed as a safeguard against error: "An affection characterized by the occurrence of local œdematous swellings, more or less limited in extent, and of transient duration.

Severe colic is sometimes associated with the outbreak. There is a marked hereditary disposition in the disease."

The physician practicing in Southern California, where neurotics and exotics flourish side by side, has abundant opportunity to study the vaso-motor neuroses of which urticaria is the type. Very few tourists visit Los Angeles without suffering, sooner or later, from hives. Change of water, combined with the reckless consumption of fruit, seems to be the exciting cause. Whatever its origin, the eruption is usually sensitive to touch, and worse in cool air. Hepar sulph., the drug *facile princeps* in chronic urticaria, is almost specific in both the acute and chronic forms. While carefully studying hepar in its relation to various neuroses, my attention was strongly centered upon the frequency with which urticaria occurred in connection with marked cases of angeio-neurotic œdema, and the generally accepted opinion that the latter disease and giant urticaria were identical. Hepar sulph. bears a specific relation to chronic urticaria; ergo, it must bear a similar homœopathic (*i.e.*, specific) relation to angeio-neurotic œdema. Crude reasoning, cries the purist; and yet how many a homœopathic truth has sprung from just such induction? "By their fruits ye shall know them"; and by practical bedside experience shall a remedy be tested. In Goodno's "Practice," Dr. Bartlett mentions apis, ferrum and strychnia as the drugs upon which he has chiefly relied in the treatment of angeio-neurotic œdema. My experience leads me to use apis for the acute manifestations of the disease, and hepar sulph. for its radical cure. In other words, apis and hepar are here complementary, as they so often are in ordinary urticaria.

The three following cases are reported as most thoroughly illustrative of the curative power of hepar in typical examples of angeio-neurotic œdema:

CASE I.—J. R. P., aged 38. Ranchman. Mother had been a neurasthenic for many years. Two brothers and one sister were markedly neurotic. Father had suffered from recurrent attacks of angeio-neurotic œdema. Patient's own history showed chorea when a young boy, but otherwise had always been in good health. In 1892 had his first attack of the disease, in which upper lip was enormously swollen and right eye closed. The swelling appeared suddenly, lasted a few hours,

and then gradually disappeared. From that time to the date of his first visit to me, August 10, 1900, there was not a month passed without the appearance of these swellings. Sometimes they would come on the arms and legs, "as big as a goose-egg, tense, elastic, and rather sore"; again, the hands would "puff up as large as two hands ought to be"; or the penis would "look like a great bladder of water." All the functions were normally performed, and the man, aside from a peculiarly nervous manner, was a perfect picture of health. His skin chafed easily, was slow in healing, and lips chapped in cool weather. Hepar sulph. 3x t. i. d. for six months. No recurrence after the first month.

CASE II.—E. A. B., aged 28. Drug clerk. Both parents markedly neurotic. Had always been "delicate," but no serious illness. In 1895 had frequent attacks of severe colic, with nausea and vomiting—diagnosed as appendicitis. Associated with his last seizure was a swelling of the tongue, forcing open the mouth, with profuse salivation. The under lip was also greatly swollen. These symptoms continued unabated for nearly two days. About one month later, large, elastic, painless, circumscribed swellings appeared on both arms near the elbows; and a few hours later similar swellings came on both thighs. He first came under my care October 11, 1900, with extensive œdema of prepuce and severe nausea. The history, together with absence of any organic disease, pointed unerringly to the diagnosis of angeio-neurotic œdema. This patient would faint at sight of blood; craved pickles; skin chafed easily; was always better in damp weather. Hepar sulph. 3x, as in former case. The attacks gradually decreased in frequency and severity, and vanished in January, 1901.

CASE III.—R. H. S., aged 45. Commercial traveler. Family history excellent. Patient was of leuco-phlegmatic rather than nervous temperament; "didn't know as he had any such thing as nerves." Had first attack in January, 1901, when he nearly lost his life from acute œdema of the larynx. I first saw him March 3d, with extensive œdema of tongue, which protruded from the open mouth; both eyes closed; numerous swellings on arms and legs, and entire penis resembling a huge bladder. The most careful examination failed to show any cause for the attack. Under apis he made a rapid recovery, but in two

weeks again presented himself with "goose eggs" on back and buttocks, swollen penis, and a "game eye." The next day the œdema vanished, and a sharp paroxysm of cardialgia followed. A typical outbreak of hives, sensitive and worse in cool air, was the next manifestation; and the *finale* consisted in dead-white appearance of fingers and unilateral sweating, confined to left half of body. Tendency to localized sweats was a pronounced peculiarity, sometimes limited to one side of face, then to one arm, and again to one foot. Hepar sulph. 3x, as in the other cases, with gradual improvement. No attacks during last six months.

In speaking of the treatment and prognosis of this disease, Prof. Osler writes: "The treatment is very unsatisfactory. In the cases associated with anæmia and general nervousness, tonics, particularly large doses of strychnia, do good; but too often the disease resists all treatment. I have seen great improvement follow the prolonged use of nitro-glycerin." During my twenty-two years of practice in the east, only one case of angeio-neurotic œdema came under my observation, and that resisted my best endeavors to cure. Here in Los Angeles, the Mecca of invalids, I have seen and treated, in two years, eight cases, all of whom have been greatly benefited, if not permanently cured, by hepar.

In a disease so rare and so prone to long periods of remission, it would be presumption to base any positive claim of infallibility for the drug upon cases so few in number and so limited in time of observation; but the results have thus far been so satisfactory, and the homœopathicity of the remedy so undeniable, that the facts are submitted for your verification or rejection, as clinical test shall decide.

CLINICAL RESEARCHES INTO STRABISMUS OF THE NEW-BORN. DOES CONGENITAL FUNCTIONAL STRABISMUS EXIST?—Serini finds congenital functional strabismus does exist; that it is more frequent in primiparas than in multiparas; and that a long labor and a prolonged period of expulsion increases its frequency. These results, he says, are based upon a long series of observations in the Maternity Hospital of Paris. Nearly 50 per cent. of the first-born infants, he asserts, showed a strabismus which was either alternating, intermittent or convergent. In many of the cases he found that the condition disappeared.—Serini, Paris.—*Archives d' Ophthalmologie.*

INDICATIONS FOR OPENING THE MASTOID.

BY W. W. SPEAKMAN, M.D., PHILADELPHIA.

ALTHOUGH primary involvement of the mastoid cells has occasionally been reported, its occurrence is so infrequent as to hardly merit attention in a paper devoted to mastoid inflammations. The principal causes assigned are exposure, traumatism, tuberculosis and syphilis,—the latter being the more frequent, and operates by gummatous deposits forming and degenerating within the mastoid.

The main differential diagnoses, however, between this and the secondary form are, in the first instance, entire absence of middle ear complications, either before or during the involvement of the mastoid; while in the second we have a co-existing suppurative otitis, or the history of such a condition in the past. We may, however, have conditions in the region of the mastoid simulating a true mastoiditis, and which may, in some cases, be difficult to differentiate from it. Thus extensive inflammation of the ear may, by contiguity, produce tenderness and swelling over the region of the mastoid, as may also a local circumscribed inflammation of the external canal, if it be severe, and especially if it be situated along its posterior superior wall.

These conditions may set up a sub-periosteal inflammation, and we may have extensive necrosis of the cortex, and even perforation inwards towards the cavity of the mastoid.

These cases, however, are also of rare occurrence, except in very young children, and I mention them mainly from the fact that, if recognized early, they may influence us in the management of the case. We find, then, that an acute inflammation of the mastoid process results in almost all cases from an acute or chronic suppuration of the middle ear.

The so-called “running ear” is a condition which, particularly where it occurs in children, is popularly supposed, by the laity, to be an innocent trivial matter, to be outgrown, and not to be treated, and that to stop such a discharge is to prevent nature from throwing off the impurities of the system. It is

also to be regretted that not infrequently their notions in this respect are reinforced by their medical advisers, who fall into the error of considering the affection unimportant and trifling. I might, perhaps, in this connection, be permitted to say that Politzer once described the tympanic cavity as "bounded on the north by the tensor tympanii, on the south by the carotid canal, and on the east by the membrani tympanii, and on the west by death."

The management of inflammation of the mastoid resolves itself into the non-operative and operative treatment.

By the first I mean that, if seen in its early stages, we may make the effort to abort the attack,—cause a reduction in the inflammatory products. With this end in view, we should insist that the patient remain quietly in bed and at complete rest.

Not infrequently, where an otorrhœa has existed so long as to become commonplace in the minds of patients, and particularly if they have had occasional mastoidal attacks which have had as often subsided, it will be difficult to convince them that such a measure is necessary; however, this rest and the removal of disturbing influences is a very essential factor in our efforts to secure a subsidence of the inflammation.

The diet should be regular, non-stimulating and liquid, and care should be taken to see that the bowels are kept open. If an otorrhœa has been or is present, we should ascertain if there is free drainage through the drum membrane and external auditory canal.

If there is bulging of the membrani tympanii, or if an existing perforation is inadequate for thorough drainage, we should freely incise the former or enlarge the latter with a blunt-pointed knife, making our incision extensive in the bulging portion of the membrane or in the posterior inferior quadrant. This should be followed by frequent and copious syringing with some warm antiseptic solution, to thoroughly cleanse the parts and reduce the swelling.

If it be grateful to the patient, the application of cold to the region is frequently of service, particularly in relieving the pain and allaying the inflammation. It may most readily be applied by means of an ice-bag or iced cloths, changed as they become warmed, or we may make use of the Leiter coil,

through which water as cold as may be borne is allowed to flow continuously.

It must, however, be borne in mind that cold will not always be tolerated, and we must be guided in our application of heat or cold as it may be grateful to the patient.

We should not allow ourselves to be misled by the ceasing of pain under the use of cold, and, if it be necessary to administer a narcotic for the relief of the excessive suffering which may accompany the onset of the affection, we should likewise bear in mind that it also may be apt to mask the symptoms. The temperature and pulse should be taken at frequent intervals, and the relation of the two should be carefully noted.

Likewise, we should examine the fundus oculi to notice any congestion or inflammation of the optic disk.

Nor during this time should we forget to prescribe carefully for our conditions; and, without going into the symptomatology, I will say that belladonna, ferrum phos., hepar sulph., calcarea silicea, calc. fluorica may be useful, while capsicum, probably more than any other, has been of service.

If at the expiration of from twelve to twenty-four hours the symptoms have not abated, if there is spontaneous pain and great sensitiveness to pressure, if the tumefaction of the parts continues and the ear stand well out from the head, it is likely that we shall be obliged to operate, and we may make, at least, the so-called Wilde's incision.

This may reveal the presence of a sub-periosteal inflammation with sound cortex, and may be all that is required, and this condition is not infrequently the case in very young children. It at least operates by relieving local congestion, and by clearing up to a considerable degree the true condition of affairs.

If operation is objected to by the patient or the family, and it can be closely watched, it may be left for a longer period than above stated.

If, at the expiration of from twelve to forty-eight hours, the swelling subsides, the tenderness diminishes, the temperature recedes, and the discharge from the external canal is re-established, we may consider that our efforts to abort have for the time at least been successful. If, on the other hand, they persist, what shall be our final indications for operation? How

long shall we wait for nature and our remedies to bring about a favorable result without subjecting the patient to an operation, which of necessity mutilates, is painful, and which may be tedious in its recovery, but which may, on the other hand, be the only means of saving his life, and which, if neglected an hour too long, may perforate into the cranial cavity?

As a matter of fact, each case must be decided upon its own merits, and the history of the case should be carefully studied.

Schwartz, in an admirable paper, concludes that the opening of the mastoid cells is indicated:

1. In acute inflammation of the cells, with retention of pus, if œdematous swelling, pain and fever do not subside after antiphlogosis and free incision.

2. In chronic inflammation of the mastoid, with sub-venti (periosteal) abscesses or fistulæ in the mastoid.

3. With a sound cortex of the mastoid, on account of cholesteatoma or purulent retention in the middle ear, which cannot otherwise escape, and with which symptoms arise showing that the life of the patient is in danger, or when a congestive abscess has formed in the upper posterior wall of the meatus.

4. When the mastoid appears healthy and there is no pus in the middle ear, but when the mastoid is the seat of long-continued and unendurable pain which other means fail to relieve.

It is contra-indicated when there are positive symptoms of already existing metastatic pyæmia, or of secondary meningitis, or of cerebral abscess.

Adam Politzer has formulated very similar indications to those of Schwartz, which are as follows:

1. Purulent inflammation in the mastoid process appearing in the course of acute suppuration of the middle ear; when the severe pain is relieved neither by the application for several days of cold by means of the icebag or Leiter's cooling apparatus, nor by Wilde's incision.

2. Painful inflammations in the mastoid process, occurring in acute and chronic suppurations of the middle ear, frequently preceded by great infiltration and redness of the external integument, when these are caused by stagnation of pus in con-

sequence of contractions of the external meatus or of numerous growths filling up the tympanic cavity and covering the perforation. The operation is necessary when several attempts to remove the obstacle to the escape of pus have failed, and especially so in all cases of suppuration of the middle ear when the discharge suddenly ceases while the inflammatory symptoms in the mastoid continue. The indication exists in such cases, even when the soft parts over the mastoid process are not swollen or infiltrated.

3. Persistent pain in the mastoid process, when, at the same time, the posterior superior wall of the meatus is bulged out by the inflammation having been transmitted to it from the mastoid cells, and when, after incision of the supporting wall of the meatus, the mastoid abscess is either not emptied at all or only insufficiently, and when the symptoms indicating retention of pus in the mastoid process remain unabated.

4. Obstinate pain in the mastoid continuing for days or weeks without appreciable stagnation of pus and external swelling; especially if the bone is very sensitive to pressure, as then there is probably a deep-seated abscess within the mastoid which does not communicate with the tympanum.

5. As a vital indication in every suppuration of the middle ear combined with inflammation of the mastoid, in which fever, vertigo and headache are developed during the course of the affection—symptoms which may foretell the approach of a dangerous complication. In such cases the indication is vital.

Without going into the technique of the operation, I would say that the incision should lie posterior and close to the insertion of the external ear, and should extend from the superior insertion of the auricle to the tip of the mastoid, and should be carried through the periosteum after the periosteum has been elevated, and retracting the parts until we have a good view of the field of operation, including the posterior and superior borders of the bony meatus, and the bone thoroughly examined.

If a fistulous opening is found, it should be enlarged either by means of the mallet and chisel, or, if the bone be soft and the cortex thin, it may be done by means of the sharp spoon, and our first objective point should be the mastoid antrum.

If the bone presents no suspicious points, or is hard and

smooth in its entirety, we may still, if the previous history of the case warrants it, chisel or drill our way into the mastoid antrum, being careful, of course, to keep close to the external canal and below a line drawn horizontally tangent to its superior wall.

A CASE OF TRIONAL POISONING.

BY C. H. DOBSON, M.D., ARDMORE, PA.

BECAUSE of the apparent lack of information as to the poisonous effects of trional, the following case is of interest.

The patient, a thin and anæmic woman of 50 years, took at a single dose two 15-grain powders of trional for the relief of sleeplessness and sciatica, from which she was a chronic sufferer. Five minutes later, while sitting up in bed, she complained of feeling stupid and numb, even to the lips. Her tongue seemed thick, and she almost immediately fell backward on the pillows. This was followed by incoördination of the movements of the arms. She then lapsed into a semi-comatose state from which she could be aroused, but would immediately sink back into the former condition. Vision seemed gone, and when aroused she did not recognize the members of the family.

When she had remained in this condition for eighteen hours I was sent for. On my arrival I found her in a convulsion, which lasted about fifteen minutes; during this period the eyelids twitched, the hands were clenched with thumbs in palms, there was partial paralysis of the tongue, and both upper and lower limbs were rigid. The tongue was coated white, with red edges and tips; the pupils were widely dilated. Hardly a drop of urine had been passed during the entire eighteen hours, nor had the bowels moved.

Three hours after the first convulsion a second spasm attacked her, and in this she became very violent, exhibiting great strength, and trying to bite and scratch. In other respects the attack was similar to the first. A period of stupor, with cold, clammy sweat, followed. Two hours later a third spasm developed suddenly, with general convulsive movements,

the patient screaming, fighting her nurse, and trying to bite any one who came near. A fourth and last attack occurred in four hours more; it was much like the preceding ones, but less severe.

The temperature before the spasms was 101° to 101.5° F., and from 102° to 102.5° F. after they subsided. During the greater part of the first day the thermometer registered 101° , while the pulse rate was 82; on the second day, a temperature of 102.5° and pulse rate of 90. On the third day the former rose to 104° and the pulse jumped to 110. This continued until the next day, when the temperature dropped to 103° , and continued to decrease until it became normal.

As soon as consciousness returned, which was on the second day, the patient complained of intense temporal headache, with a numb, drawing sensation in the occiput, and sharp, lance-like pains in the region of the heart. These latter continued almost constantly for twenty-four hours, and then every two or three hours for the next day, until they were controlled by spigelia and cactus. If the patient dropped asleep for a few minutes, she dreamed of ugly faces floating about her, and these caused her to waken with a start. At times, during the dreams, she felt as though some one were trying to drag her from the bed.

On the third day she seemed brighter, but still had some headache, together with a sensation as of scum over the eyeball and a great deal of lachrymation. The kidneys and bowels reacted to diuretics and purge on the second day, but refused to do their work for a week or more, except with the assistance of drugs.

The patient continued to improve until, on the tenth day, the only results were sluggishness of kidneys and bowels, and some nervousness.

VARILOUS OPTHALMITIS, AND ITS TREATMENT.—The authors state that, after having seen three cases of blindness, the result of this trouble, in previous epidemics, they recommend the employment of a one to five-hundred-strength solution of methylene blue.

Among six hundred and ninety-one cases of small-pox they found forty-five cases with complications of the conjunctiva and cornea. This method of treatment in this epidemic was so successful that they did not lose a single eye. —Courmont and Rollet, Lyons.—*Annals d' Oculistique*.

EDITORIAL.

OSTEOPATHY.

To criticize is always a thankless task, and never more so than when we endeavor to examine critically a new theory of disease and cure. By some our efforts are regarded as a waste of words, time and space, while by others, as prompted by professional jealousy. And yet, in the words of "Editorial Comment," in *American Medicine*, on the latest vagary of the founder of Osteopathy, "it is we who err when we are indifferent to the power and cruelty of the delusions of popular ignorance."

Sweeping denunciations and ridicule are not, however, the best weapons to employ in our conflict with delusion and ignorance, but impartial and sober criticism; and with this spirit we wish to examine into the merits of Osteopathy, quoting directly from its own literature, to discover in how far its system is consistent and coherent, or the opposite.

While popularity is justly rejected as a safe criterion of actual worth, its presence always points to the existence of something upon which it must rest. In the case of individuals, this is found to be some trait of character which appeals to the popular heart; in the case of intellectual or scientific movements, some principle which finds response in the popular mind.

In the medical world, or, more definitely, in the therapeutic field, the various methods of treatment, crude and absurd as many of them are, could not have gained the following that they have, had not there been in each one of them some fundamental principle which proved attractive and plausible to the general public. The common principle which underlies all of the vagaries in the art of healing is the conviction of the uselessness or harmfulness of the drug-treatment of disease. We find in them all, tirades against the drug-doctors, and the uncertainty of the methods employed by them, backed up, un-

fortunately, by the utterances of many distinguished physicians. Medical skepticism, found in the ranks of all schools, has only itself to thank for the widespread revolt against the medicinal treatment of disease, and the existence of the almost numberless sects as protests against it. Can we expect the public to believe in that in which we physicians have no confidence? Will it not rather, and of right, turn to those who, starting from the same point of skepticism in the old, offer something new, in which they profess the most unbounded confidence? From this point of view it is not difficult to understand the growth and popularity of the new methods of healing. Osteopathy, among other movements of this kind, undoubtedly owes much of its popularity to the emphasis with which it reiterates the fact that it employs no drugs, but that it appeals to Nature's force, which it only seeks to free from all obstacles which may interfere with its operation. "Osteopathy has not been in the field long enough to expose the rascality and stupidity of the whole system of drug-taking, but it has opened the eyes and minds of tens of thousands to the futility, the criminality, of remedies of this character."

There is no doubt that the trend of all schools at present lies towards the practice of giving as few drugs as possible, and trusting more to the *vis medicatrix natureæ*; but it is, we think, a false deduction that, therefore, the giving of no drugs is the most perfect practice.

What is Osteopathy?

"English bone-setters reformed surgery along the line of rational treatment of fractures and dislocations twenty years ago. Osteopathy is now carrying this work to a refinement and perfection hitherto unknown. It is finding slight slips and twists of one's bones at the basis of many diseases supposed to belong to the medical rather than the surgical field, and it is successfully curing those ills by putting the skeleton back into correct adjustment."

"Osteopathy is not a system of physical exercises, as most people infer when they first hear of it. It is not at all a form of massage, nor a new application of Swedish movements." "The osteopath accomplishes the desired result by an intelligent and scientific method of manipulation of the different parts of the body."

What is disease, according to the tenets of Osteopathy?

"If there is one thing that Osteopathy is emphasizing above another, it is the need of a new definition of disease. It aims to give a definition of disease from the standpoint of cause, rather than from the standpoint of effects." "Osteopathy sees that disease, instead of being an enemy at which twelve thousand drugs are to be hurled, is rightly viewed as a friend, rendering a disciplinary and cleansing and reformatory service to the bodily functions which need such service. Disease is "dis"-ease. There is physical machinery to enable ease to remain with us. When "ease" goes, the machinery is out of line." "Disease is simply a disturbance. Disturbance of what? A disturbance of natural processes. The root of sickness is generally to be found in obstructed cell action."

"The osteopathic-technical definition of health is the number of cells it can break down per second and be replaced by as good." (!!) "The human body is a perfect machine, complete within itself for all the work imposed upon it to live; but, like all machines, it does get out of repair. How? Osteopathy has discovered what physicians for centuries overlooked—that first it *gets out of mechanical repair* before there is any resulting disease tolerated in the body."

"The first cause of every human ill is a mechanical derangement of some one or more parts of the machine of life." "Is there a slipped bone for every disease? No. Osteopathy never said so. But there may be." "It is an osteopathic idea that most ills which beset mankind begin as slight mechanical disorders of the body." "It is, then, in and through our nerves that all the phenomena of life move and have their being. Ill-health can be described wholly in nervous changes. Osteopathy is not, therefore, entirely at variance with medical theories in proclaiming the nervous origin of disease, nor does it overturn precedents when it sets about curing disease by treating the nervous tissue. Nothing more radical than passive motion is employed."

"Osteopathy clearly recognizes that force, vital force, exists behind all phenomena, and that, to affect phenomena or outward conditions, they must reach this force."

"Illness from the osteopathic point of view assumes a somewhat mechanical complexion. There is scarcely any form of

sickness but that can be referred, directly or indirectly, to the cell and its environment, and the action of its environment on it." "Mechanical principles are employed to allow chemical and vital principles to do their intended work."

"A natural flow of blood is health, and disease is the effect of local or general disturbance of blood; to excite the nerves causes muscles to contract and compress venous flow of blood to the heart; and the bones can be used as levers to relieve pressure on nerves, veins and arteries."

"The touch of a finger-tip on a certain nerve has restored what is popularly known as a cross-eye to normal, straight vision. Cataracts have been sent adrift."

"Osteopathy, unaided by serums or any drug whatever, has been signally successful for a decade in treating diphtheria, and more recently small-pox."

Dr. Still, the founder, alleges that he was "immunized" against small-pox in adult life by the cantharidin of a fly-blister which his mother put on his hip for white swelling, while he was still a boy. During the process many pieces of bone "had come out of the superior crest of the ileum." Following his advice, "thousands upon thousands of cases" have been "immunized" by the use of cantharidin used as a blister, presumably without osteopathic manipulations.

Dr. Still says: "I also believe that the philosophy that I present can, and will be found just as protective against measles, diphtheria, scarlet fever, leprosy, and syphilis, as against small-pox and other infectious contagions."

"Nine-tenths of the cases that come to osteopaths are cases on which medical science has exhausted itself. Osteopathy controls all of the fevers of this or any climate, all contagious diseases, all diseases of the kidneys and of the spine. It deals with the brain, the liver, the lungs, the heart, and every division, part and function of the whole human body."

Prospectus of the Philadelphia College and Infirmary of Osteopathy.

"Candidates for graduation must have attended four terms of five months each, must pass a satisfactory examination in each branch of the curriculum of study, and give satisfactory evidence of general proficiency in all departments of the college."

Text- and Reference-Books on the following branches are recommended: Anatomy, Histology, Pathology, Bacteriology, Physiology, Physiological Chemistry, Chemistry, Psychology, Urinalysis, Poisons, Obstetrics, Gynæcology, Practice, Surgery, Public Health, and Venereal Diseases.

Tuition for the course, \$500 in cash, or secured notes.

Columbia College of Osteopathy, Chicago, Ill.

"To a man or woman who is desirous of adopting an honorable, dignified profession, which is readily learned, easily acquired, and *which yields immediate and satisfactory financial results*, Osteopathy comes as a God-send." "Osteopathy—it pays well." "Our Home Study Lessons not only cover the subjects usually treated in courses and works upon Osteopathy, but also teaches methods of practice original to this college, which cannot be obtained elsewhere. It teaches Osteopathy divested of all its unnecessary features, and brought down to a practical basis, and also teaches improved methods of applying its principles." "Our lessons are twelve in number, and are neatly printed on good, strong paper, and handsomely bound in a flexible silk-covering, and in appearance compare favorably with some of the most expensive *de luxe* editions of choice literature." "Some students are able to take up and complete a lesson in a day or two; others will require at least a week upon a lesson. Generally speaking, the average student will be able to cover the twelve lessons in about one month's time." "Any man or woman of common, average, every-day intelligence can easily acquire a working knowledge of Osteopathy, sufficient to begin successful practicing at once."

"We think it well to state that any person of average intelligence and application, studying our lessons according to our plan, should experience no difficulty in meeting the requirements of the examination."

"Our graduates are awarded the degree of Doctor of Osteopathy, which entitles them to attach the letters D. O. to their names."

"The price of this complete course, including the examination and diploma, is \$25, or \$5 cash, accompanying the order for the course, \$5 on receiving the diploma, and the balance, \$15, in payments, six, nine and twelve months after graduation."

From the above quotations, taken from the *Philadelphia Journal of Osteopathy*, *The Osteopathic Physician*, the *Prospectus of the Philadelphia College and Infirmary of Osteopathy*, and from *Osteopathy, The Twentieth Century Profession*, Chicago, we think the following conclusions are justifiable :

1. Osteopathy offers no new contribution to the science of medicine.

2. It is only one of many methods of treating disease, differing only in a slight degree from similar ones already in use, in the attempt to prove its universal applicability by scientific half-truths.

3. It makes the same exaggerated claims as to its efficacy which are regarded as characteristic of quackery.

4. The better educated of its adherents find difficulty in reconciling its fundamental principle of the mechanical cause and treatment of disease with their knowledge of universally accepted facts.

5. In spite of this, this class of adherents is desirous of upholding the good name of Osteopathy by insisting upon a thorough medical training for its graduates.

6. There are others, however, who care for the "profession of the twentieth century" only as an easy road to financial success, regardless of the ignorance and credulity which they tend to foster by their efforts to extend their system.

7. Under the circumstances, the making the teachers and practitioners of such a system "legal practitioners" must be regarded as a misfortune, in view of the requirements set for other medical schools.

IS CANCER DERIVED FROM TREES?

UNDER the above startling heading, the editor of *Homœopathic World*, London, considers a recent communication made to the French Academy, and translated from *Le Signal*. This communication has caused a sensation—character of sensation not stated—as it tends to prove that there is an analogy between cancerous tumors in man and the vegetable tumors which give birth to the *Nectaria*, the parasite of the cancer of trees. This is mentioned as explaining the considerable num-

ber of malignant tumors observed among the inhabitants of the country upon the borders of forests; for instance, in the midst of the orchards of Normandy. It may also explain why cancer is so prevalent among sweeps. This may be due to the germs, which, resisting heat, are mixed with the dust from wood which sweeps are obliged to respire. And now comes the climax: Dr. Bra inoculated some trees with human tumors. In the trees so inoculated the pernicious fungus was developed in profusion, whilst the neighboring trees remained free from it. This is really wonderful—if true, and we wish we knew; for we had begun to think of a certain ideal spot in the wilds of the Adirondacks which is full of trees and tree tumors. But if the intoxicating fragrance of the forest is full of cancer germs, why, we shall take our chances, next summer, among the saline breezes of dear old New Jersey.

CLERGYMEN AND PATENT MEDICINES.

THE manufacturers of nostrums have so long profited, in a measure, by the support of certain clergymen and the patronage of religious journals, that it is a pleasure to note that one ministerial association has taken a stand against one of the most common and dangerous forms of quackery. On March 4th the East Pennsylvania Conference of the Evangelical Church passed resolutions condemning the use of patent medicines. These resolutions averred that “the government, instead of endeavoring to check the growth of the liquor evil, appears to be pandering to its interests; that unprincipled persons, in order to get gain, have concocted compounds or so-called ‘sure cures,’ ‘cure-alls,’ ‘specifics,’ ‘bitters,’ and the like, the base of which is alcohol, often bad whiskey, which cause users to become addicted to strong drink;” and that, “as a church, we greatly deplore these conditions, and pledge ourselves to the support of Gospel temperance.”

We believe that the charges as above outlined are true, and that the virtues of many tonics reside in the bad whiskey they contain. But we also feel that the reverend gentlemen might have attacked patent medicines because of their general fraud-

ulent character. Knowing the influence of the clerical profession over the laity, they should seize every opportunity to protect their parishioners from the nostrum shark, as they would from the pickpocket. More than this, they owe this duty to themselves for the honor of their profession. Too often do we observe in the religious and lay press advertisements of this or that "cure-all," to which is appended an endorsement by some minister. The cloth should place its ban upon such disgraceful conduct.

SUTURE OF THE ABDOMINAL WALL.—Davison (Chicago) advocates the method of approximation of layer to layer, peritoneum to peritoneum, fascia to fascia, and skin to skin, by independent planes of suture. The ideal suture material is one that can be rendered sterile by boiling in water, that will remain sterile while in the tissues, and that will cease to exist in the tissues when healing is complete and its function has been accomplished. These indications are not met by absorbable sutures, nor the permanent buried sutures like silver wire or silk.

The author makes use of silkworm gut as a continuous suture, the ends of which are left out at the angles of the wound, to be removed by traction when healing is complete.

The peritoneum is first closed by a continuous herring-bone suture of silkworm gut. The suture is shirred to take up all the slack, and the ends are left hanging out at the angles of the wound. It is removed at the end of a week or ten days by cutting one of the ends close to the skin, then making traction on the other end, and thus drawing it out, while the patient relaxes the abdominal wall by elevating the thighs and shoulders. For the closure of the fascial layer, or linea alba, coarse selected Spanish silkworm gut, thirteen inches long, is used. A small, reverse bow-knot is tied four or five inches from the end of the strand. The suture is introduced in the fascia back from the edge of the wound and drawn tightly up to the knot, and the wound is closed by the continuous herring-bone stitch. At the last stitch the suture is shirred up tightly, and another reverse bow-knot is tied. The ends are allowed to hang out at the angles of the wound. It is removed at the end of two weeks by simultaneous traction on both ends, which unties the knots, when the suture can be pulled out. The skin is closed by the Halstead continuous subcuticular stitch of silkworm gut. The sutures may be colored for identification—red with alcoholic solution of carbol-fuchsin, black with silver nitrate, or blue with an alcoholic solution of methylene blue. These sutures can be used in appendectomy or any laparotomy in which the incision is in a straight line. Moreover, they act as capillary drains from each layer. The same method can be applied to any of the standard operations for the radical cure of inguinal hernia.—*Annals of Surgery*, March, 1902.

GLEANINGS.

THE RELATION BETWEEN TONSILLITIS, ARTICULAR RHEUMATISM AND ERYTHEMA NODOSUM.—Dr. Menzer, at a recent meeting of the physicians of the Charité Hospital, of Berlin, reported the results of his investigations on this subject. In the excised tonsils of cases of articular rheumatism beginning with tonsillitis, he found in the bloodily infiltrated peritonsillar tissues numbers of diplococci and short streptococci; therefore, he regards the tonsils as the portals of entrance of the infective process, articular rheumatism, whence the germs gain entrance to the blood. In pneumonia he thinks the infection takes place rather from infectious deposits in the fauces than through the deeper respiratory tract. In scarlet fever and measles he looks upon the ordinary bacteria as the causal germs. The same germs give rise to ordinary bronchitis and tonsillitis, and measles and scarlet fever are only general reactions of the system to these germs. In the discussion following, these views were somewhat disputed, as some assumed that a certain specific streptococcus was the cause of articular rheumatism, though the mode of infection was granted.—*Muenchener Medicinische Wochenschrift*, No. 50, 1901.

Frank H. Pritchard, M.D.

A CASE OF TUMOR OF THE CEREBELLUM.—Dr. R. Schmidt, of Vienna, at a recent meeting of the Medical Society of Internal Medicine, of that city, presented a patient, a young man of twenty-three years, who, a year before, had fallen on his head, which accident was followed by loss of consciousness. Since then he has suffered from vertigo, difficulty in walking, with an inclination to fall backwards. Besides these symptoms, he presented nystagmus when he looked to the right, amaurosis, a choked disk, exaggeration of the tendon-reflexes, etc. These symptoms and their progressive character led him to diagnose a glioma of the cerebellum. In the discussion, Prof. Nothnagel thought that these symptoms might be also due to a tumor situated in the corpora quadrigemina, compressing the vein of Galen.—*La Semaine Médicale*, No. 53, 1901. (I once had an experience with a supposed tumor of the cerebellum, which diagnosis was confirmed by an able diagnostician, for the patient had the choked disk, the staggering, drunken gait, terrific headaches, "cerebral vomiting" and attacks of coma, which, on account of their progressive character, seemed to point to dissolution. Yet this young man recovered completely. He had as close a symptom-picture of a cerebellar tumor as I ever saw or read of. He must have had a chronic meningitis. This should teach us not to be all too certain in our diagnoses, but ever to doubt, for, as an eminent Danish clinician has well said, "It is divine always to doubt.")

Frank H. Pritchard, M.D.

HEART DISEASES IN CHRONIC ARTICULAR RHEUMATISM.—Dr. Barié asserts that heart affections complicating chronic articular rheumatism are by

no means as rare as is generally assumed, for their relative frequency was taught by Charcot in 1863, who thought they developed during acute exacerbations of the primary joint disease.

Heart complications in these chronic forms of rheumatism are most often noted in elderly persons, though they have been seen in young patients, and even in children. It was formerly held that pericarditis was the only possible complication, but later it developed that endocarditis, and finally, in association with these former, one may meet with hypertrophy of the heart, cardiac degeneration, and sclerosis of the coronary arteries. This pericarditis may be a pericarditis sicca, which may bring about symphysis of the pericardium; there may, however, be a collection of fluid in the sac, often of a hæmorrhagic character. This endocarditis most often attacks the aortic valves in older persons, though it may also in younger ones, and gives rise to an incompetency; the mitral valves are less often affected. The further development of these cases is that of other heart cases. The further study of these cases permits one to divide them into groups—in one the connection between the chronic rheumatism is very doubtful, for in the past history of the patient several infectious diseases will have been found which may have caused the heart complication. In another group the heart affection seems to have developed after an acute or subacute exacerbation of the joint-affection. In a third group the articular disease seems from the very beginning to have pursued a chronic course, and no acute aggravation was noticed; in this latter division a number of patients are met with who have arterio-sclerosis, alcoholism, obesity; and here the joint affection hardly plays any important rôle in the production of the heart disease, for a valvular lesion or a myocardial disease is rather at the bottom. But now and then patients will be observed where none of these factors are noticed, and especially in children and youthful persons, where a heart disease develops at the end of a joint-affection. The etiology of these cases is obscure; they are surely not of microbic origin.—*Hospitalstidende*, No. 36, 1901. (Probably both the joint and heart diseases have a common, a dyscrasic, origin. I once observed a case in an old man who was arterio-sclerotic, with a urine of low specific gravity, which contained a trace of albumin; he was a great smoker. He was seized with a seemingly unimportant arthritis of the right hip-joint, apparently sub-acute in its course and gouty in character. This left him within a week, and he immediately was affected with an endocarditis, from which he slowly recovered, to become subject to a condition resembling Stokes-Adams' disease. He had three or four attacks of very severe pulmonary embolism, which greatly endangered his life. Then his liver would increase to an enormous size, and he would become almost cachectic—"la maladie se faisait dans le foie," as Hanot said. He lived on for four years or so, with intervals of fair health for an old man, and finally died asystolic.)

Frank H. Pritchard, M.D.

A TREATMENT OF CROUPOUS PNEUMONIA—HYPODERMATIC INJECTION OF QUININE.—Professor Petzold, of Magdeburg, Germany, asserts the hydrochlorate of quinine to be a specific in the treatment of croupous pneumonia. He administers it hypodermatically, and *only* in those cases where Fraenkel's pneumococcus is found in the sputa; in those in which Friedländer's bacillus is detected, or indeed any other germ, it has no influence. He claims it to have an antitoxic action. Curiously enough, he admits that it does not pre-

vent the disease from migrating, hinders no complications, does not shorten the process nor hasten the crisis. But, on the contrary, the influence of the general condition of the patient is very pronounced. *It acts like an antitoxin.*

It was given to all adults with croupous pneumonia in the Magdeburg City Hospital, but to none under ten years of age, and only rarely, and in special cases, to those of ten to fifteen years. This method of treatment is indicated in grave infection, with prostration, cyanosis, weak pulse, and superficial respiration, or when the disease complicates pregnancy and delirium tremens. He injected one-half a gram of the hydrochlorate, dissolved in seventeen grams of water, or one gram in thirty-four grams of water, injecting daily about a gram into the sides of the abdomen. The injections are repeated as the general system requires them; rarely more than three are necessary. Patients between ten to fifteen years received 0.25 daily.—*Hospitalstidende*, No. 52, 1901. (Those symptoms are quite good homœopathic indications for quinine. Yet I believe that we often fail to get the greatest good out of our remedies in such grave cases by not "pushing" them enough. A serious condition often requires a powerfully acting remedy. The dose really ought to cut but a small figure in homœopathic practice.)

Frank H. Pritchard, M.D.

TYPHOID FEVER COMPLICATED BY A HÆMORRHAGIC TENDENCY.—Dr. A. Tramer has observed, out of 98 cases of typhoid fever, 2 cases of this disease complicated by a peculiar inclination to parenchymatous hæmorrhages. He lost them both from profuse hæmorrhages, which rapidly set in and were quickly fatal. There was hæmorrhage from the nostrils, bowels and skin. One died at the end of the third week, the other six days after the fever had ceased. Differentially to distinguish these hæmorrhages from those due to typhoid itself, he points out the parenchymatous character of the hæmorrhages, the dark color of the blood, the simultaneous bleeding from the buccal mucous membrane, the appearance of petechiæ over the whole body, and the late appearance of the hæmorrhages. Probably the complication was due to sepsis—a mixed infection.—*Muenchener Medicinische Wochenschrift*, No. 49, 1901.

Frank H. Pritchard, M.D.

A DISEASE OF CHILDREN, AFFECTING SEVERAL MEMBERS OF THE SAME FAMILY, AND CHARACTERIZED BY PERMANENT CHANGE OF THE PULSE, SYNCOPAL AND EPILEPTIFORM ATTACKS AND SUDDEN DEATH (STOKES-ADAMS' DISEASE).—Dr. Morquio, calling attention to the fact that this disease has until now not been observed in children, and rarely in adults before the fortieth year, describes a family where five children out of eight were affected with a disease which strikingly resembled Stokes-Adams' disease. Besides, in the one case where a necropsy was done, neither an arterio-sclerosis nor a fatty degeneration of the myocardium, which are usually the cause in older patients, was detected. The writer only had two of the children under his care, two boys of eight and five years respectively, who, without any personal or hereditary antecedents worthy of note, had presented at times, since their fourth year, epileptiform attacks, or fainting fits. Three of their brothers had died suddenly, one at ten, the other two at eight years, during an attack of this kind. The family consisted of three other children, —a daughter of seventeen years, who had remained free from the disease; a second daughter, who had died of typhoid at the age of six; and, finally, a

boy of two, who is unaffected so far. Both the children which the writer treated presented the same symptoms—epileptiform or syncopal seizures, which would come on at the least pretext, at varying intervals. They presented a notable bradycardia, 60 pulsations to the minute, alternating with irregularity, intermittence and inequality of the pulse. Auscultation revealed nothing abnormal in the circulatory system. The other organs were healthy. One of these children, who had passed through an attack of influenza without the fever modifying the heart in the least, suddenly died while at play some time after, during a syncopal seizure. The necropsy revealed only slight dilatation, with some fatty overgrowth of the right ventricle which had been left by the grippal infection. He regards the condition in all these children as due to a congenital malformation or a state of hereditary weakness of the cardio-bulbar centre.—*La Semaine Medicale*, No. 50, 1901. (I once had a case of Stokes-Adams' disease follow a metastasis of subacute rheumatism to the heart. The patient lived for years after, and finally died asystolic. His pulse at times would descend to 32 to the minute, with epileptiform seizures, which would cause the patient to fall down, looking deathly pale and pinched. No remedy gave him any particular relief, though intestinal antiseptics gave him most comfort. There was associated albuminuria and arterio-sclerosis. There was a cardiac murmur at all four orifices.)

Frank H. Pritchard, M.D.

SANTONIN.—This drug has generally been looked upon only as a reliable anthelmintic, but it has now been found to possess a much wider range of action, and to be of special value in the treatment of epilepsy and locomotor ataxia. It will not be a surprise to homœopaths to learn that its newer therapeutic accomplishments have been quite along the lines of *similia*. The *Medical Times* says that its physiological action is markedly upon the nervous system, producing, in large doses, great weakness, tremor, perspiration, coldness of the extremities, vomiting, and, not infrequently, quick, sharp convulsions, terminating in death from paralysis of respiration. The effect upon the vision is very marked; at first everything appears blue, which speedily turns to a greenish yellow, which may be followed by total blindness, lasting a week or more. Its pronounced effects upon the nervous system gives us a clue to a remedial agent of great power in influencing general changes of nervous sensibility. In its action we have an excellent reproduction of the symptoms of epilepsy and the pains of locomotor ataxia. Let us see what therapeutic deductions have been made from all this. Lydston claims to have obtained better results from santonin in epilepsy than from the bromide treatment. In the fulgorant pains of locomotor ataxia the editor of the *Times* says that 2 grains given three times a day yield him better results than any other drug. The pains disappear while the patient is under its influence. It seems to us that santonin is a very likely drug for a careful and exhaustive proving.

CERTAIN CONSIDERATIONS UPON THE ACTION OF IRIDECTOMY IN GLAUCOMA.—As a result of investigations upon this subject, Daulnoy arrives at the conclusion that Abadie's theory of dilatation of the ocular vessels through the influence of the sympathetic system is more tenable. In concluding his article he says:

1. It is impossible that iridectomy should relieve glaucoma simply through

the establishment of a free communication between the anterior and posterior chambers.

2. Acute glaucoma is probably the result of a lesion of a part of the bulbar centre, producing dilatation of the arteries of the orbit, and, in consequence, a reflex contraction of the chorioidal muscle which determines the hypertension.

3. Iridectomy acts well in the following types of diseases: Acute and sub-acute, with corneal disturbance and absolute remission between the attacks. The probable explanation of the action of the procedure probably lies in the destruction of the iridal plexus and the consecutive reflexes acting upon the irido-cilio-chorioidal muscle.

4. In chronic simple glaucoma the lesion of the bulbar centre is different, and acts more especially upon the trophic fibres.

5. Iridectomy has no effect upon chronic simple glaucoma. In such cases, and if a marked and prolonged treatment with eserine, associated with pilocarpin, does not give good results, sympathectomy, which, so far, has acted excellently, should be performed.—*La Clinique Ophthalmol.*

William Spencer, M.D.

HEREDITARY NYSTAGMUS WITHOUT APPARENT LESION.—Two cases are described by Jacqueau, the patients being mother and daughter. In each there was a rotary nystagmus with a movement of the head in the opposite direction. The mother's vision was ten-fifteenths, and the daughter's one-half of normal. The mother had a compound hypermetropic astigmatism, with the major axis horizontal, while the daughter had a hypermetropia of one and one-half diopters. There was not a trace of hysteria or evidence of other general nervous disturbance. The author agrees with Knies in attributing this disease to some central lesion.—*La Clinique Ophthalmologique.*

William Spencer, M.D.

PARALYSIS OF THE ASSOCIATED MOVEMENTS OF THE EYES.—The case was that of a woman who experienced a severe attack of paralysis, with loss of consciousness, lasting for six hours. Following this, "she could not see anything in its right place." Upon examination it was found that there was an insufficiency of the external rectus muscle of the right eye, with a weakening of elevation of the left eye, though this symptom could not be definitely asserted as being dependent upon either the superior rectus or inferior oblique muscle. Moreover, there was inability to lower either eye more than ten degrees beneath the horizontal meridian. He believes that a lesion of the nuclei along the floor of the fourth ventricle and the aqueduct of Sylvius can probably be excluded in his case by the fact that these nuclei are in such close proximity that it is difficult to conceive of one being affected and not the others.

He considers that the most likely explanation of the condition is that of a lesion of the extra-nuclear centres, which are probably located in the quadrigeminal tubercles. After a careful study of the case, he sums his findings as follows: There exists besides the nuclei of origin of the oculo-motor nerves a series of co-ordinating centres (regulators of the associated movements of the ocular globes). These extra-nuclear centres are probably occupied in co-ordination of reflex binocular movement. There are also supra-nuclear centres which seem to play a rôle in co-ordination. To these may be added a num-

ber of cerebellar centres whose action is that of maintaining the relations and assuring an equilibrium of the visual axes.—Poulard, Paris, *Archives d'Ophthalmologie*.

William Spencer, M.D.

TAPE-WORMS.—Dr. B. C. Oyler tells some prize worm-stories in the March number of *The American Medical Journal*, and gives in detail his favorite method of ridding the intestinal canal of these unpleasant and troublesome residents. Every physician, at times, feels the need of a reliable and safe vermifuge mixture, for the removal of these intestinal parasites is surely not best accomplished by remedies selected according to the therapeutic law of *similia*. The problem is a mechanical one. We must first place the worm *hors de combat*, and then remove it intact. After this has been accomplished, we may, by suitable remedies and hygiene, correct the ill health that has been occasioned by the unwelcome guest. There are many methods in vogue, some of which are so objectionable to the patient as to occasion a decided preference for the worm. Dr. Oyler administers to his patient a brisk saline cathartic upon the evening *previous* to treatment. Next morning the remedy is given upon an empty stomach, the patient having gone without supper and breakfast. The formula is as follows :

Oleo Resin Male Fern,—half a fluid drachm.

Chloroform (Squibb's),—one fluid drachm.

Croton Oil,—one minim.

Castor Oil,—enough to make the ounce.

Now, if the tasteless castor oil can be procured for this mixture, it will not be objectionable in taste. The mixture should be slightly warmed before it is administered. There could be no objection to repeating this dose in exceptional cases, should there be no response to the first one. And, in case the bowels do not move vigorously, there could be no objection to giving an additional half-ounce of the castor oil. We presume this mixture has been arranged for an adult dose. The author narrates one case in which it seemed impossible for the huge bunch of worms to come away—nine worms, from twelve to twenty feet in length. He introduced a rectal tube, and irrigated the colon with saline solution. This brought away the mass easily. After that the colon was again irrigated, bringing away several heads.

SYPHILIS AS SEEN BY THE OPHTHALMIC SURGEON.—Primary syphilis is rarely seen by the ophthalmic surgeon; in the secondary stage iritis is common; interstitial keratitis is frequently seen as a manifestation of hereditary syphilis; but the greatest number of cases are in connection with the tertiary period, and these, too, in patients apparently cured for a long period, and who have been under routine treatment for months and years. True interstitial keratitis sometimes occurs as a tertiary manifestation. The iris is frequently affected. Simple plastic iritis occurs as an early secondary symptom; nodular iritis between the sixth and ninth month of infection, and between the first and third years after primary infection a mild form of iritis, with opacity of the vitreous. Scleritis similar to rheumatic scleritis, and a rare gummatous cyclitis are met with, and are distinctly tertiary lesions.

A violent form of retinitis, with much opacity of the vitreous and great decrease of vision, and usually affecting both eyes, sometimes occurs as one of the earlier tertiary symptoms.

Optic neuritis is common as a tertiary lesion—then there are disturbances of mobility due to a syphilitic lesion occurring in the course of some of the oculo motor nerves.

From the large list of syphilitic ocular affections frequently occurring in patients who have, with their physicians, made every reasonable effort to get rid of the disease, the author concludes that the present routine treatment is inadequate. The routine treatment referred to is protoiodide of mercury in doses of gr. $\frac{1}{2}$ to gr. $\frac{1}{4}$ three or four times daily, and at intervals potassium iodide in large doses.

The author believes the most efficient method of treatment is the old-fashioned blue ointment rubbed in morning and evening for a month, with tonics and good food; then potassium iodide in increasing doses for two or three months; then the mixed treatment continued for a long time.—Frank Buller, M.D., *Montreal Medical Journal*.

William Spencer, M.D.

OCULAR PAIN; ITS SIGNIFICANCE, VARIETIES AND TREATMENT.—Ocular pain is an invaluable symptom, and its absence in inflammatory conditions of the eye may be, as a rule, considered as a favorable sign.

Very little pain occurs in connection with conjunctival affections, but the cornea is especially sensitive, and this symptom may be a very important guide in suggesting corneal disease where the lesion is minute.

In all cases of doubt the corneal surface should be carefully inspected through a lens.

Photophobia is explained as due to exposure by minute ulceration, etc., of the corneal plexus. Iritis is not always accompanied with pain, and the amount of pain is not always an indication of the severity of the attack; but when the inflammation extends to and involves the ciliary body, a distinct tenderness of the globe on palpation is present. In the different forms of iritis the pain symptoms vary. In syphilitic iritis it is very variable, but generally persistent. In rheumatic iritis it is usually present in marked degree, but chiefly at night time. In syphilitic iritis the pain when once relieved does not recur. In the rheumatic form the pain is of neuralgic character, differing from the throbbing, inflammatory type in syphilis, and its subsidence is generally the first indication that the attack is passing off. Dry heat is the best application in this class, and nothing acts so well as the old-fashioned bran poultice. Leeches are not necessary, nor are sedative drugs.

Pain in the atrophied globe implies the immediate necessity of enucleation, whether there be danger of sympathetic ophthalmia or not. In glaucoma the pain is not due simply, he thinks, to stretching of the sclera, but he suggests that it is due to the compression to which the ciliary processes are subject during the attack, where the only treatment, of course, is iridectomy.—Percy Dunn, *Jour. American Med. Assoc'n*.

William Spencer, M.D.

ON THE COMPARATIVE VALUE OF THE VARIOUS PREPARATIONS OF SILVER IN OPHTHALMIC WORK.—Efforts have been made to introduce some salt or compound of silver which may be as efficacious as the nitrate, while free from its disadvantages.

The following compounds have been supplied: Actol, itrol, argonin, argen-tamin, nargol, largin and protargol. Actol has no advantage. Itrol (soluble

in water 1 : 4000) may be used as a powder directly to conjunctiva; it appears to be an excellent antiseptic, with considerable penetrating power. Argonin is inferior to both protargol and largin. Argentamin has the disadvantage of containing a very small amount of silver (2.6 per cent.). Nargol may be used in 5 to 10 per cent. solutions, which cause no pain when instilled into the conjunctival sac, and is pleasanter to use and less sticky than protargol. Largin is not precipitated by albumin and chlorides, must be protected from light and freshly prepared. Its chief claim is that it contains more silver than any other synthetical preparation (11.8 per cent.). In acute contagious conjunctivitis, due to the Weeks bacillus, the writer has had better results than with any other drug. This preparation will stain the conjunctiva, and it is, therefore, unwise to continue its use longer than two or three weeks at a time.

Protargol (8.3 per cent. silver) is not decomposed by albumin alkalies, or weak hydrochloric acid; it should be protected from the light, and freshly prepared. A 2 per cent. solution of protargol equals in its germicidal effects a 2 per cent. solution of silver nitrate, but it has a much greater penetrating power, and can, therefore, exert its germicidal quality longer than silver nitrate.

Protargol has no caustic action, and causes little or no pain. The writer has had better results with 10, 20 and 30 per cent. solutions than with weaker ones. He has used it in 50 per cent. solution for trachoma, soon diminishing secretion and shortening the duration of the disease.—Gustave Hartridge, London, Eng., *British Medical Journal*.

William Spencer, M.D.

CAUSES OF SALPINGITIS OTHER THAN GONORRHOEAL.—(Deaver and Moore.)—There is an idea very prevalent among the laity, and also among medical men, that salpingitis and pyosalpinx have their origin alone in gonorrhœa. It is true that the majority of cases are gonorrhœal, yet there are other important causes. Because of the extent to which this view is believed, many women are misjudged. The general recognition that there are causes other than gonorrhœal is especially important to innocent husbands and unmarried women.

The causes of salpingitis other than gonorrhœal are: *post-puerperal infection, appendicitis, tuberculosis* and *minor gynecological operations*. One of the most important causes is what may be termed "the terrible douche habit." The indiscriminate and careless use of the douche robs the vagina of its natural protection from infection, and often implants an infection of unusual severity.

Minor gynecological operations are responsible for many exacerbations of latent disease within the tubes. The practice which is being advocated by German surgeons and taken up by Americans of curetting in the office and permitting the patient to go home in an hour or two, is to be greatly deplored.

Post-puerperal infection is responsible also for many cases. It may develop directly after labor, or an interval may elapse between the labor.

Appendical inflammation may readily involve the right tube because of its contiguity and by means of the lymphatic system.

Tubercular salpingitis is occasionally met, and it is either secondary to tuberculosis in other parts, or by direct implantation from infected testicles,

seminal vesicles or prostatès.—*American Journal of the Medical Sciences*, March, 1902.

(It is our opinion that the writers have not gone out of the way in calling attention to the sociological aspect of the question, because of its importance.

William F. Baker, A.M., M.D.

GENERAL REMARKS ON ASYLUM DYSENTERY AND ITS TREATMENT BY INJECTIONS OF PERMANGANATE OF POTASH.—(MacDonald.)—Asylum dysentery, or so-called "colitis," has been the source of much anxiety in many institutions for the insane in this country. The infectious nature of this disease has long since been recognized. It has been ascribed to overcrowding, unsanitary conditions, etc., but since these conditions are practically unknown in our more recent institutions, the matter must rest as a pure infection. Again, most of the inmates are hale and hearty.

The treatment advised consists in the irrigation of the bowel with a weak permanganate solution (two to four grains to the pint). Following the injections the number of motions is considerably less, and the irrigation need be continued rarely beyond the third day. In every one of the cases the patient recovered. Apparently the permanganate acted not only as a disinfectant, but as a styptic. In the more severe cases, milk as a diet was found to be rather unsatisfactory. It not only was rejected, but it increased intestinal irritability. The main article of diet used was a mixture of beef tea and rice, together with port wine. Two classes of cases give bad results: (a) tuberculous, (b) general paralytic.

In concluding the article, he says: "While my experience of the permanganate has not been extensive, I think it has been sufficient to warrant the results being made known, and I am hopeful that this short paper may be the means of inducing others to try the treatment as opportunity occurs."—*The Lancet*, March 1, 1902.

William F. Baker, A.M., M.D.

A CLINICAL LECTURE ON FEEDING IN GASTRIC ULCER.—(Brunton.)—The treatment outlined is from two to five days on rectal feeding, depending on the severity of the case and a gradual return to mouth feeding in small quantities. Under this treatment patients usually recover in about six weeks. In some cases a return of the symptoms is very apt to occur if the diet has been too free. All food which is indigestible or which proves irritating is to be avoided for quite a period of time. The skins of all fruits should be carefully avoided, and any fruit or pulp which contains hard fibres. The large and the tough fibres of meats act only as irritants, but they tend to block up the pylorus and retain the food in the stomach a long time, so that it undergoes fermentation, and acids, as lactic, butyric and hydrochloric, are formed. This hyperacidity is particularly undesirable. Too much food should not be given at any one time; therefore it is well to begin the treatment of gastric ulcer by giving, in addition to the enemata, a tablespoonful of milk with a tablespoonful of lime-water every two hours, and gradually increasing the quantity as we find the patient is able to stand it, without causing pain. If it causes pain, we diminish the quantity. We can then, after a few days, increase the proportions of milk, and give one of lime-water to four of milk. If the patient is not standing the modification well, it is best to reduce the amount or go back to the former modification. Careful and thorough mastication is

to be insisted upon, and many of the difficulties of feeding will be overcome. Following the use of the milk, custard is to be recommended, and then pounded fish and meats, followed by chicken.—*The British Medical Journal*, March, 1902.

William F. Baker, A.M., M.D.

CONTRIBUTIONS TO THE STUDY OF SPINAL FRACTURE. WITH SPECIAL REFERENCE TO THE QUESTION OF OPERATIVE INTERFERENCE.—After a careful review of the symptomatology, Walton comes to the following conclusions: (*a*) There are no symptoms which establish (otherwise than through their persistence) irremediable crush of the cord; (*b*) while total relaxed paralysis, anaesthesia of abrupt demarcation, total loss of reflexes, retention, priapism and tympanites, if persistent, point to complete and incurable transverse lesion, the onset of such symptoms does not preclude a certain degree, at least, of restoration of function; (*c*) the prognosis without operation is grave; (*d*) while the results of operation are not brilliant, they are sufficiently encouraging to warrant us making the practice more general; (*e*) in most cases it will be wise to operate within a few days of the injury; but a delay of some hours is advisable, partly on account of the shock and partly to *eliminate* the diagnosis of simple distortion; (*f*) we have no infallible guide to the extent of the lesion.

The operation at worst does not materially endanger life nor affect unfavorably the course of the case, and may at least reveal the lesion and relieve the pain; it may some time save the patient from death or from helpless invalidism of the most distressing character. Instead of selecting the occasional case for operation, we should rather select the occasional case in which it is contra-indicated (the patient with great displacement of the vertebrae, the patient with high or rising temperature, the patient plainly moribund, the patient still under profound shock); (*g*) the dura should be opened freely, not sutured; drainage is not necessary.—*Boston Medical and Surgical Journal*, March 6, 1902.

William F. Baker, A.M., M.D.

ONE CAUSE OF LOSS OF HAIR.—Dr. Jackson thinks that if our young men would oil their scalps occasionally they would often avoid baldness. Some people think that sins of commission are more potent in the production of premature baldness than are the sins of omission; but Dr. Jackson may be right. There is one interesting fact in relation to the constant use of hair tonics which we should like to see thoroughly investigated. We have seen some cases of ill health in which albuminuria, bloody urine and the presence of tube casts could be demonstrated, which only yielded to treatment after we had discovered and stopped the constant use of the cantharidal hair tonic. The possible causal relationship is only suggested; but it would seem to be at least an interesting coincidence, worthy of further investigation.

ADRENALIN AS AN ADDITION TO SOLUTIONS FOR LOCAL ANÆSTHESIA.—Elsberg (New York) uses a mixture of adrenalin and cocaine or eucain for the production of local anaesthesia and blanching of the field of operation, which will be found advantageous in many minor operations. He has found that injection of one drop of the 1 to 1000 solution of adrenalin chloride under the skin will produce within one minute an area of blanched, almost bloodless tis-

sue some two inches in diameter. This remains so for from six to twelve hours. Weaker solutions, as 1 to 5000, or 1 to 10,000, or even 1 to 15,000, will produce the same result, only more slowly, and the blanching will disappear quicker. No deleterious effects, as sloughing or ecchymosis, ever occurred. It does not in any way interfere with the anæsthetic action of eucain or cocaine, and is of decided benefit in combination with these drugs, as it stimulates the heart, and will prevent the congestion, and hence the pain, which is so apt to follow soon after the anæsthetic effects of the eucain or cocaine have worn off. In addition, it almost entirely does away with the oozing of blood from the wound. The author recommends that a sterile solution of adrenalin chloride be obtained of 1 to 1000 strength, and the required amount of this be added to the eucaine, cocain or Schleich mixture just before it is to be used. For ordinary work, a solution containing 1 to 5000 or 1 to 10,000 is used. When the injected solution has to be a large one, 1 to 15,000 or 1 to 20,000 is advised.—*American Medicine*, March 1, 1902.

Gustave A. Van Lennep, M.D.

LIGATION OF THE ABDOMINAL AORTA FOR ANEURISM.—Morris (New York) reports the fourteenth recorded case in which the abdominal aorta was ligated. The patient died on the third day after operation from septicæmia. She was a colored woman, twenty-four years of age, with a history of aortic disease dating back four months. In addition to the objective signs of aneurism of the aorta, there was present an epigastric tumor pulsating so forcibly that the pulsations were visible at a considerable distance from the patient.

A six-inch incision was made from the ensiform cartilage downwards. The aneurismal sac extended from the cœliac axis to beyond the mesenteric vessels. It was decided to try temporary ligation of the aorta in order to allow the sac to fill with clots, and then to remove the ligature and allow the circulation in the extremities to continue as before. A soft rubber catheter was used in order to avoid injury to the tunica intima. It was carried around the aorta with the aid of an aneurism-needle, threaded with a loop of silk. The catheter was tightened around the vessel, and held in place by a long clamp. The ends of the catheter and clamp were allowed to protrude through the abdominal wound, the rest of which was sutured. The ligature was applied at a point about two inches below the aneurism, and one and a half above the bifurcation of the aorta. The operation lasted thirty minutes, but the author believes the time can be cut down to fifteen minutes.

When the ligature was tightened, the pulse went to 148, respirations to 48. Nine hours after the operation the temperature was 100°, pulse 104, respirations 36. There was intense pain in the legs, and a feeling of numbness, which required the use of morphine. Nineteen hours after the operation the prick of a pin could be felt over the vastus muscles, but the legs showed general loss of sensation. Twenty-two hours after the operation the pulsation of the aneurism began to diminish, and in about three hours the aneurism had disappeared. Twenty-seven hours from the operation the ligature was removed by uncoupling the forceps and drawing out the catheter. This was followed by immediate pulsation in both femorals, return of sensation, and control of the sphincters. Death was due to septicæmia on the third day.

The post-mortem examination showed that the septicæmia was caused by

gangrene of small portions of the bowel which had lain in contact with the steel forceps. The aneurism was a dissecting one. It was solidly filled with blood-clots, but leaving a patent aorta. There was no sign of injury to the aorta at the site of ligation, though an embolus was found in the left internal iliac artery. The author appends notes on the thirteen previously reported cases of ligation of the abdominal aorta.—*Annals of Surgery*, February, 1902.

Gustave A. Van Lennep, M.D.

THE IMPORTANCE OF A PROPER DIETARY REGIMEN IN THE TREATMENT OF CHRONIC HEART AFFECTIONS.—(Illoway.)—There can be no question that the matter of diet is of much importance in the treatment of heart affections, but that its importance is not fully appreciated is also evident. That the stomach has an influence on the heart has long since been recognized, and Stokes warns his readers not to be too hasty in making a diagnosis of organic cardiac affection where symptoms of hepatic derangement or of gastric disturbance are present. Huchard and See tell us that angina pectoris may depend on a deranged stomach, and Potain, that even dilatation may have such origin. The relationship between the heart and the stomach is more than that of position, for the "*vagus*" exerts the controlling influence on the heart, besides innervating the stomach. From this we may see that the way in which the stomach can influence the heart is either by means of the "*vagus*" or by its contiguity.

(a) *The "Vagus."*—When the food is of improper character or improper quality, the undue irritation may be reflected on the heart directly, or indirectly, in the way that the irritation is primarily reflected on the pulmonary vessels, and the heart becomes secondarily affected in consequence. The manifestations of such undue irritation may be (a) disturbances of rhythm, (b) painful sensations in the præcordium, (c) dilatation of the right heart.

(b) *Contiguity.*—When the stomach is empty it is collapsed on itself. When food is taken, it distends in all directions, and the diaphragm is pushed up. When the heart is normal, and there is no overfilling of the stomach, there is no interference in the functions of the heart, but, with a chronically diseased organ, it cannot drive down the apex into the distended stomach, and the systole becomes imperfect. As a result, the ventricular cavities are not emptied, the blood in the auricles is dammed back, and the organ becomes surcharged with it. The resulting symptom is a suffocative paroxysm.

It is very evident from the cases cited that the question of food is one of greatest importance to the patient. It is clearly shown that the patient may be made either miserable or comfortable and well nourished as the food is adapted to his condition or not.

The rules formulated for the management of diet are :

- (a) All foods that have bulk must be excluded.
- (b) All flatulent foods must be excluded.
- (c) Only foods that are readily digestible should be taken.
- (d) All foods must be well cooked.
- (e) All meals should be small.
- (f) There should be sufficient interval between meals.

As illustrative of the above rules, the following diet lists are given :

- (1) *Functional disturbances*: 6 A.M., a glass of milk ; 8 A.M., Hoff's malt

(wineglass) and a dish of oatmeal; at 10.30, glass of milk; 1 P.M., small, broiled steak or two small chops (with a little horse radish as condiment), one-half glass of water and a little fruit jelly; 3.30, one and a half tablespoons of dry sherry; 4 P.M., a glass of milk; 6 P.M., malt, steak and milk; 9 P.M., sherry wine. Occasionally, malt and wine through the night.

(2) The diet list for the organic heart disease included fresh eggs and milk, lamb broth, cocoa and crackers, rice, and well-cooked farinaceous foods. All food should be well cooked, but never fried. Eating moderately and slowly is also advised.—*The American Journal of the Medical Sciences*, March, 1902.

William F. Baker, A.M., M.D.

EPILOPEXY IN CIRRHOSIS OF THE LIVER WITH ASCITES.—Torrance (Birmingham, Ala.) recommends that the surfaces of the spleen and liver be not irritated, as there is always more or less oozing from them, and this makes an excellent culture medium for any germs that may accidentally get into the abdomen. Besides, the operation was designed to relieve the strain on the liver-cells, and we should attempt to divert as much of the current from the liver as possible. He advises tapping the patient the day before the operation, then with local anæsthesia make a small incision, and simply suture the omentum without even exploring the abdomen. However, he farther on quotes from Rolleston and Turner: "The increased vascular supply to the surface of the liver may, by improving the nutrition of the hepatic cells, enable them to undergo compensatory hyperplasia. The compensatory hypertrophy of the liver will enable the organ to perform more efficiently its important antitoxic functions, and so lead to a latency of the symptoms."

The normal collateral circulation of the portal system is given after Sappey, as follows: "Veins connecting the portal vein with the phrenic vein and vena azygos major, and running subperitoneally between the folds of the hepatic ligament. Another large vein running in the round ligament connects the left branch of the portal with the epigastric and other veins of the abdomen. The coronary veins communicate freely with both azygos veins through the œsophageal plexus, and the inferior mesenteric with the internal iliac by means of the middle and inferior hæmorrhoidal plexuses."—*Annals of Surgery*, March, 1902.

Gustave A. Van Lennep, M.D.

TRAUMATIC RUPTURE OF THE MESENTERIC ARTERIES.—Aldrich (Cleveland) reports a rather unique case. The patient, a man fifty-three years of age, weighing about two hundred and forty pounds, sustained a fracture of both bones of the right leg by falling on the sidewalk, coming down with great force on the buttocks. The fracture was easily reduced, no anæsthetic being necessary, but a week after the patient died from symptoms of internal hæmorrhage, the source and location of which it was impossible to determine. The post-mortem examination revealed a quantity of blood in the abdomen, which came from the fractured wall of several of the mesenteric arteries. The mesentery contained an enormous amount of fat, and it was supposed that the tremendous tug exerted upon this structure by the violent fall upon the buttocks was sufficient to lacerate it and produce hæmorrhage.—*Annals of Surgery*, March, 1902.

Gustave A. Van Lennep, M.D.

MISAPPLIED MECHANICAL SUPPORT TO WEAK ANKLES OF CHILDREN.—Wilson (Philadelphia) deprecates the growing tendency to apply to children's

shoes some more or less rigid support in the form of high uppers, stiff leather counters, whalebone, and even arch raisers of various materials. He calls attention to the fact that all children are flat-footed before they learn to walk, because the muscles have not developed the arches of the foot, and use is required to bring the muscles into full development, which can only be obtained by *perfect freedom from restraint*. He recommends, as the least objectionable shoe for young children, a low shoe or slipper which possesses the advantages of sandals. Nothing can be gained by the upper, which has the constant disadvantage of cramping the ankle, and thereby preventing its full, free use and development. The author states that the most serious sprains of the ankle that he has seen in children have been in those who have had inadequate muscle and joint function.

In rachitic children it often becomes necessary to apply aids to mechanical function not alone because of muscle insufficiency, but also on account of the lack of stability of the bones. Deformities of the feet are frequently associated with malformations of the long bones, such as the valgus, foot, and bow-legs and knock-knees, each depending upon the other and upon the constitutional disease for their development. And here no routine plan of treatment can be laid down, for discernment is required to meet the mechanical inefficiencies by mechanical aids that will be of benefit, and not prove injurious. The author believes it to be the duty of the medical profession to discourage the indiscriminate use of high counters, corset-shoes, elastic anklets, arch-raisers, and sole-wedging, which are known to be injurious, unmechanical, and productive of permanent loss of function.—*Annals of Surgery*, March, 1902.

Gustave A. Van Lennep, M.D.

THE CHOICE OF OPERATION FOR MYOMAS (FIBROIDS) OF THE UTERUS.—(Olshausen.)—The operation for uterine myoma in relation to the preservation of the health of the individual has entered recently into a new phase. The important question at present is, how far shall preservation of the uterus be attempted, and whether the ovaries shall be sacrificed?

This question concerning the ovaries was discussed by Professor Zweifel and Professor Rosthorn at the Berlin Congress of the German Gynecological Society, in 1899. Both of them emphasized the fact that the continuance of the function of the ovaries after the operation is not by any means a matter of indifference to the welfare of the patient. Zweifel states that the climacteric, artificially and suddenly produced, is accompanied by far more complaints than when it occurs spontaneously. Zweifel, therefore, always leaves the ovaries. He also makes the observation that removal of the corpus uteri so affects the ovaries that they atrophy after a few years, and permanent symptoms of the climacteric follow. He therefore leaves a portion of the body of the uterus with the endometrium whenever possible, which allows menstruation to continue. This operation then becomes one of resection rather than of mere supra-vaginal amputation.

Professor Rosthorn lays down the rule that, wherever possible, the ovaries should remain after all radical operations for myoma of the uterus, to reduce the climacteric symptoms to the minimum.

Werth also insists on the importance of allowing one ovary to remain for the benefit to the patient. It has been noticed for some time by all operators that those patients suffer very little from climacteric disturbances in whom

the uterus has been removed without extirpating the ovaries. On the contrary, those patients who have had supra-vaginal amputation of the uterus with removal of the ovaries for uterine fibroids suffer exceedingly and persistently from climacteric symptoms. This is due not to the cessation of the menstrual flow, but to the absence of the internal secretion of the glands. In all probability, many psychoses after operation depend on this cause. In forty-eight cases of supra-vaginal amputation in 1900 and 1901, the writer removed both ovaries in only eleven cases; and of these, ten were between forty-six and fifty-four years old.

The question of the liability to disease of the ovaries thus left deserves further consideration. The writer has repeatedly had to remove the ovaries later for cystic degeneration or other disease, and thinks it may be due to interference with the circulation of the ovary. He therefore avoids ligation *en masse*, and close to the uterus away from the ovary. He also believes in supra-vaginal amputation of the uterus and leaving a small portion of the endometrium in women who may menstruate whenever this is practicable. Enucleation is practicable for a few cases, and the abdominal route admits of a more conservative operation than the vaginal.—*Centralblatt für Gynäkologie*, No. 1, 1902.

George R. Southwick, M.D.

RUPTURE OF AN OVARIAN CYST DURING LABOR.—Kleinertz reports the case of a primipara in whom a small ovarian tumor ruptured during labor, and from which a fatal septic peritonitis developed. He urges the importance of removing the ovarian tumor in every case where it complicates pregnancy. The danger of the operation is not materially increased, and it is much less than the danger from rupture of it during labor; besides, the surrounding conditions are more favorable than if the operation must be performed in the puerperal state.—*Centralblatt für Gynäkologie*, No. 38, 1901.

George R. Southwick, M.D.

RETRODEVIATIONS OF THE WOMB.—(Rosenwasser.)—The writer summarizes as follows:

1. A retroverted womb uncomplicated by disease should be replaced and supported by a pessary.
2. Retroversion complicated by diseased womb or impaired pelvis floor, the womb being movable, requires preliminary plastic operation to restore the normal condition before using a mechanical support.
3. Suspension operations should not be done simultaneously with the plastic, in face of the probability that a pessary can sustain the womb in position.
4. Retroversion complicated by aggravated prolapsus requires simultaneous plastic and suspension operations to effect a cure.
5. The treatment of retroversion with fixed womb is that for pelvic inflammation. Whenever the latter requires laparotomy or colpotomy, the retroversion becomes subject to such surgical treatment as may appear best suited to the particular case.
6. Retroversion, simple or complicated, in which mechanical support and plastic operation have failed to cure or relieve, and in which the symptoms demand relief, constitutes a proper indication for a suspension operation.—*American Journal of Obstetrics*, November, 1901.

George R. Southwick, M.D.

THE RELATIONSHIP BETWEEN HUMAN AND BOVINE TUBERCULOSIS.—Adami (Montreal) discusses Koch's recent utterance concerning bovine tuberculosis as a cause of infection in human beings, and reaches the following conclusions :

1. Bovine tuberculosis is easily conveyed from cattle to cattle, and, whether by inhalation (the most common method), by the milk (in calves), by contamination of the stalls and drinking-water through the agency of the saliva and nasal discharge, through the genito-urinary passages, or by intrauterine infection (very rare), this transmission from one animal of the bovine species to another is far and away the commonest mode of infection in cattle ; so common that, *for practical purposes*, all other modes may be neglected.

2. Human tuberculosis is transmissible to cattle. Pure cultures of these bacilli rarely cause infection. Mixtures of tubercle bacilli with other micro-organisms (as in sputum) appear to be more infectious. The difficulty in inducing artificial tuberculosis favors the idea that natural infection of cattle with human bacilli must be of singularly rare occurrence.

3. Swine appear to be fairly easily infected with both human and bovine tubercle bacilli, and when infected with the former, these gain an increased virulence for guinea pigs and rabbits. But while through the use of infected milk these animals become frequently infected from cattle, conditions favoring the reverse process are rare. Thus, while it may occasionally be that swine, or possibly other domestic animals, act as intermediaries in the passage of tuberculosis from human beings to cattle, the conditions favoring such transmission from man to the hog, or from the hog to cattle, so rarely show themselves that again, for practical purposes, this mode of infection may be neglected.

4. If this be so, it should be possible to eradicate bovine tuberculosis in a region in which human tuberculosis continues to be widespread.

5. Human tuberculosis, in the majority of cases, is conveyed from human being to human being by inhalation ; more rarely it is conveyed through the alimentary tract ; still more rarely through the genital tract, through surface wounds, and from the mother to the foetus during intrauterine life.

6. Everything points to the fact that in the main the bacilli causing infection in man are derived from previous cases of the disease in man.

7. By sojourn in the human body and passage from man to man the human tubercle bacilli have acquired properties differing from those acquired by bacilli which have passed through cattle. Their shape differs, the rate of growth and the appearance of the growths outside the body are different ; their virulence toward the animals of the laboratory is also different.

8. These differences are not, however, sufficiently marked or constant enough to permit us to conclude that we are dealing with distinct species. On the contrary, the evidence at our disposal points clearly to the fact that in the different species of animals we encounter, at most, *races* of tubercle bacilli which, by growth in the bodies of animals of another species, take on the characteristics of the race of bacilli peculiar to that species.

9. Bovine tuberculosis can be transmitted to man, and this either through wounds or through the digestive tracts.

10. By passage through cattle the tubercle bacillus gains increased virulence for cattle, rabbits and guinea pigs, but lessened virulence for man and (it would seem also) for carnivorous animals.

11. Save in the very rare cases of wound infection, there is a significant lack of evidence that bovine tubercle bacilli infect adult human beings.

12. It is infants and those of early age who are liable to be infected by the tubercle bacilli of bovine origin, and this through the agency of milk. The statistics bearing upon the continued frequency of tuberculosis in children and upon the relative frequency of intestinal and abdominal tuberculosis in children must be accepted as conclusive evidence on this point.

13. Even with children, a consideration of the great frequency of bovine tuberculosis in certain regions, and of the absence of any record of tuberculosis affecting those supplied from a given "milk round," leads to the conclusion that the bovine bacilli have not heightened virulence.

14. The few positive records we possess of direct transmission of tuberculosis from cattle to man through the agency of the milk indicate that infection is brought about only by the employment of milk of cattle which are very extensively diseased, more especially of those suffering from udder disease. Such milk contains enormous numbers of bacilli. In other words, large numbers of tubercle bacilli are required in order to infect human beings with bovine tuberculosis. This, again, is an indication that the bacillus cannot be regarded as having gained a heightened virulence for man, and that infection is not very readily communicated.

15. Animals showing physical signs of tuberculosis (for mild grades of the disease afford no physical signs), and, above all, those exhibiting udder tuberculosis, should therefore be condemned, and under no conditions should their milk be used for food.

16. Where there is tuberculosis in a herd, Bang's method should be employed, the animals reacting to tuberculin being separated from the healthy ones; the milk from the reacting animals, for whatever purpose used, should be Pasteurized so as effectively to destroy the tubercle bacilli.

17. The great cause of infant mortality is inflammation of the stomach and intestines (gastro-enteritis and diarrhœa), and this is proved to be mainly brought about by the use of badly kept and fermenting milk. Wholly apart, therefore, from the question of tuberculosis, it is imperatively necessary that greater care should be exercised by all concerned in the distribution of milk. The general measures taken to lessen this, the greatest scourge of childhood (prohibition of the use of milk from cattle showing any form of sickness, Pasteurization of milk, etc.), will equally lessen the danger of the transmission of tuberculosis from cattle to man.

In conclusion, the author regrets that Koch left it to be inferred that legislation against bovine tuberculosis is in excess of what is necessary. This, he protests, was little less than criminal on his part.—*Phila. Med. Journal*, Feb. 22, 1902.

F. Mortimer Lawrence, M.D.

PNEUMONIA IN THE LIGHT OF MODERN RESEARCH.—In a paper with the above title, read before the New York Academy of Medicine, February 18, 1902, Dr. Stephen Smith Burt insists that pneumonia is a systemic, self-limited disease, with localized pulmonary manifestations. It is almost universal in its distribution. Though it occurs at all seasons, the winter and early spring are its times of greatest prevalence. Both in frequency and in fatality it is in direct ratio to the density of population. With the excep-

tion of a few years in childhood, it pursues mankind, and with increasing deadliness, through all the decades from infancy to old age. It is often the harbinger of death in alcoholism, certain chronic diseases, and in various conditions of debilitation. Of the aged it is the typical terminal malady. The negro race in this country is very prone to succumb to its ravages. Pneumonia is undoubtedly an infectious disease, and chiefly by means of the sputum, in the same manner as pulmonary tuberculosis.

In the course of the ensuing discussion, Dr. W. Gilman Thompson said that a large number of observations had borne out the statement that pneumonia is becoming more prevalent. The diplococcus of pneumonia is ubiquitous, and is frequently present in the mouth, but we do not know what makes some of these organisms virulent while others are not. He firmly believed in the importance of disinfecting the sputa. He had met two or more epidemics of pneumonia in hospital practice, and had promptly checked them by isolating all the pneumonia patients, emptying the ward and disinfecting it. Dr. Beverley Robinson stated that four years ago he had expressed the belief that by the use of inhalations of pure creasote the pneumonia patient could be benefited and the attendant protected. He is not prepared to admit that creasotal possessed any advantage over creasote. He agreed with Dr. Charles E. Nammack, who stated that his main reliance was on the proper use of four drugs, viz., strychnine, nitro-glycerin, oxygen and alcohol. Dr. Andrew A. Smith was of the opinion that from the moment an active propagating pneumococcus is present in an air-cell the person has pneumonia. As a result of the growth of the pneumococcus, toxins are developed and are absorbed, and from these arise the well-known phenomena of pneumonia. So long as the process of consolidation extended, just so long would toxins continue to be found. He was strongly of the opinion that it was possible to so act upon the whole mass of blood, that the air-cells in the lungs could be made an unfavorable nidus for the propagation of the pneumococci. The beechwood creasote would probably do this, while creasotal should accomplish the same result with more comfort to the patient. By such treatment the disease would be so altered that defervescence would take place in about 90 per cent. of the cases by lysis instead of crisis. Mention had been made of nitro-glycerin, and this always pleased him. Whenever a pneumonia patient appeared cyanosed, nitro-glycerin should be given rather than digitalis.—*Med. Record*, March 8, 1902.

F. Mortimer Lawrence, M.D.

THE DIAGNOSIS OF CIRRHOSIS OF THE LIVER.—J. C. Wilson (Philadelphia) states that the chief objection to the classification of the cirrheses into atrophic, vascular, toxic, on the one hand, and hypertrophic, biliary, infective, on the other, is that it does not conform to facts. An objection of minor importance is to be found in the failure to provide for the cardiac and syphilitic cirrheses, cirrhosis due to pneumoconiosis, that form resulting from chronic obstruction to the bile-ducts, chronic perihepatitis—capsular cirrhosis—and other forms of minor importance. Hawkins, in Allbutt's *System*, does not recognize a vascular or toxic form corresponding to the atrophic form of writers (Lænnec's cirrhosis) and a biliary or infective form (Hanot's cirrhosis), but states that "two forms of cirrhosis of the liver are induced by the excessive use of alcohol."

Wilson summarizes the etiologic relations as follows: (a) In general, toxic,

and in particular, alcoholic, plumbic, gouty, diabetic, rachitic, and the like. We must include here forms of interstitial hepatitis due to chronic phosphorus-poisoning and the abuse of condiments. The assumption that interstitial auto-intoxication gives rise to interstitial hepatitis lacks confirmation. (b) In general infections: in particular, the specific febrile infections are occasionally followed by chronic interstitial hepatitis. Malaria produces similar changes, and syphilis gives rise to three well-characterized forms, namely, diffuse syphilitic hepatitis, commonly congenital, gummata, which undergo fibroid transformation, and an extensive perihepatitis, with increase in connective tissue of the portal canals. (c) Mechanical irritation: the long-continued exposure to an atmosphere laden with dust-particles, such as produce pneumoconiosis, may also be a cause. (d) Congestive: the chronic hyperæmia of the blood-vessels occurring in heart disease gives rise to interstitial hepatitis—the cardiac liver. (e) Obstructive: the result of chronic obstruction in the bile ducts.

The writer regards diagnosis as practically impossible when the liver is of normal size. When, however, the liver is diminished in size, there is, as a rule, malnutrition, enlargement of the spleen, distended veins, and increased girth, due to ascites. It is well to remember that these symptoms can occur in an interstitial hepatitis in which the liver is not only atrophic, but even somewhat enlarged. Adhesive pylephlebitis closely resembles this atrophic variety, but the etiologic considerations, and the rapidity with which the peritoneal effusion develops and re-forms after tapping, are important to differential diagnosis. The increased size of the liver in the hypertrophic form—Hanot's disease—is associated with splenic tumor, deep and persistent jaundice, and occasional attacks of fever of remittent type. Diagnosis in either form is commonly impossible until an advanced stage is reached. The diagnosis of hepatic capsulitis—the capsular cirrhosis of authors—is usually attended with insuperable difficulties. The symptoms are those of the atrophic form, jaundice is not usually present, the kidneys are granular, and perisplenitis and proliferative peritonitis may be associated.

In conclusion, it is affirmed that:

1. The term cirrhosis is an unfortunate one. It has been applied to conditions wholly unlike, etiologically, anatomically and clinically, which have, however, in common, an overgrowth of the connective tissue of the liver.

2. The term chronic interstitial hepatitis is to be preferred.

3. Alcohol is by far the most common cause of interstitial hepatitis, alike in the cases in which the liver is of normal size or slightly enlarged, in the atrophic form and in the hypertrophic form.

4. The symptoms of this condition are, in many cases, ill-defined, and not rarely the liver is not changed in size or contour. The clinical diagnosis, in a large proportion of cases, is therefore impossible.

5. In the presence of definite symptoms, and of the signs of enlargement or diminution of the liver,—that is to say, in terminal conditions,—the diagnosis is commonly a simple matter.—*Med. News*, February 8, 1902.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF DIABETIC COMA.—Mayer (New York) states that severe cases of diabetes mellitus which show a marked reaction to Legal's and the ferric chloride test, with increased ammonia and β -oxybutyric acid secre-

tion, are always on the danger-line of coma, and our efforts should be directed toward warding off this complication as long as possible by reducing, if possible, the acidosis and ammonia excretion. He advises that, in order to lessen the acetone and diacetic acid excretion, rigid dietetic rules be relaxed, and the patient given moderate quantities of farinaceous broths, bread, potatoes and levulose. Eventually, of course, sugar being thus increased, inanition will ensue. For the avoidance of impending coma, all authorities recognize that the most important point is the reduction of the acidosis and increased ammonia excretion, and advise the administration of very large quantities of alkalis, especially the bicarbonate of soda, by mouth, rectum, intravenous injection or hypodermoclysis. He refers, also, to the paper of Schwarz, read before the Congress für Innere Medizin, in Berlin, in 1890, in which it was shown that the higher oxidation products of glucose and glycuronic acid, called respectively glyconic and sugar acids, when given in large quantity, produce a very decided diminution in the excretion of acetone and diacetic acid. Schwarz related a case in which diabetic coma was repeatedly overcome by the administration of glyconic acid, neutralized by sodium bicarbonate.

The writer states that another rational method of treatment would be the introduction into the system of a sufficient quantity of ammonia to unite with the various acids found in the condition of acidosis, and records a case in which coma was repeatedly combated successfully by the administration of urotropin, twenty grains to sixty grains daily. His reason for using urotropin is that it is a chemical combination of ammonia and formaldehyde, which, in the presence of an acid, splits up into its component parts, and the ammonia is thus permitted to enter the circulation and neutralize the acids, while the formaldehyde passes out in the urine.—*Med. Record*, March 8, 1902.

F. Mortimer Lawrence, M.D.

THE EARLY DIAGNOSIS OF TYPHOID FEVER BY EXAMINATION OF THE BLOOD FOR THE BACILLUS.—At the meeting of the Société Médicale des Hôpitaux of Paris, on December 27, 1901, M. Jules Courmont pointed out the great value of the presence in the blood (in from 70 to 80 per cent. of cases) of the typhoid bacilli in the early diagnosis of typhoid fever, especially when Widal's reaction failed. He examined the blood in nine cases, and succeeded in obtaining the bacillus in pure culture in all cases. The blood was taken aseptically at the bend of the elbow, and was cultivated in small flasks containing 20 centimeters of bouillon, into which some drops of blood were received, and in larger flasks containing from 300 to 1000 cubic centimeters, into which from 2 to 4 cubic centimeters of blood were received. Incubation took place at 37° C. The bacilli obtained showed all the characters of the typhoid bacilli. M. Courmont drew the following conclusions:

1. The typhoid bacilli were present in the blood in all ordinary and grave forms of typhoid fever (the question of slight and abortive forms he reserved).

2. It appeared early in the disease. He found it as early as the fifth day (he had not had an opportunity of examining the blood earlier), and remained in the blood until the end of the third week. It might persist longer in fatal or prolonged cases, and at necropsies it might be found in the general circulation. There was no relation between the presence of the bacilli in the blood and the agglutinating power of the serum.—*The Lancet*, February 8, 1902.

F. Mortimer Lawrence, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

CONDUCTED BY O. S. HAINES, M.D.,

with the collaboration in German literature of C. Sigmund Raue, M.D.

USEFUL REMEDIES IN THE TREATMENT OF NEURASTHENICS.—At the last meeting of the British Homœopathic Society there was a very interesting discussion upon the medicinal therapeutics of neurasthenia. Dr. Ellis, of Liverpool, the essayist of the evening, said that in his experience picric acid had been the remedy which most closely resembled the general symptomatology of the disease. He would not advise this remedy below the 6th centesimal. In cases in which pain and gastric symptoms were prominent, he had preferred oxalic acid. Where vertigo is prominent, he uses phosphorus; especially if there is pulsation in the head and sexual irritability. Where there is great muscular exhaustion with asthenopia and pain in the nape of the neck, he recommends *actea racemosa*.

Dr. Goldsbrough considers neurasthenia a condition of increased irritability of the nervous system, with weakness of result. Hysteria is a distinctly mental state, and such symptoms must be eliminated before prescribing for neurasthenia. He agreed that picric acid is the most generally useful drug, but he would not use it below the 12th centesimal, as he had seen marked aggravation from the 6th centesimal. He thought that this remedy and phosphoric acid cover the ground in neurasthenia. For the annoying sensations of pulsation, so common in this affection, he recommends valerian or digitalis. Anacardium is suitable for those cases in which self-consciousness and sexual irritability are prominent. For insomnia of such cases, he recommends small doses of kali brom., but when the insomnia is due to excessive mental activity, constant flow of thoughts, he prefers hyoscine.—*Hom. World*, February.

CRATÆGUS IN CARDIAC WEAKNESS.—Here's a genuine novelty. A case reported by Dr. Duncan illustrating the beneficial effects of the new remedy, *cratægus* in cardiac weakness. The novelty lies in the fact that Dr. Duncan has taken pains to tell us all he knows about the case, and has furnished us with sufficient data upon which to prescribe the remedy again in a similar case. So many of the reports upon *cratægus* have been lacking in such clinical data. The patient was an old man. The pulse rate was only 26. Dr. Duncan examined him in different positions, and made a diagnosis of hypertrophied and dilated heart. The apex was found to the left and behind the sixth rib. This old man was subject to attacks of cardiac weakness, in which no pulse could be found at the wrist. After rubbings and stimulants, his heart would seem to start again, with slow and measured beat. He seemed practically dead dur-

ing these attacks. The doctor considered this case to be one of extreme bradycardia (bradycardia). Digitalis did not act kindly in this case, but produced a rapid trembling, distressed feeling at the heart, with some cerebral confusion. After the crataegus had been given, the man escaped his attacks for over one year. No mention of dose is made. We suppose the tincture.—*Homœopathic Recorder*, Feb. 15, 1902.

THE PSEUDOMEMBRANOUS INFLAMMATIONS OF THE RESPIRATORY TRACT IN CHILDHOOD.—The leading paper in February *Hom. Jour. of Pediatrics* is from the pen of Dr. C. Sigmund Raue. A very interesting article, in which the author makes it clear that the Klebs-Löffler bacillus is capable of assuming two entirely different rôles, inducing in the one case a most overwhelming toxæmia; in the other merely a fibrinous exudate, unaccompanied by even slight constitutional symptoms. Every physician occasionally encounters a case of rhinitis in which a pseudomembrane has formed in one of the anterior nares without a single symptom, similar to those which accompany a mild faucial diphtheria, being present. Such a condition is due, in the majority of instances, to the bacillus in attenuated form. The danger in such cases lies in the tendency of some physicians to overlook the virulent contagiousness of this apparently benign affection. In laryngeal diphtheria we must take into consideration the rôle assumed by the anatomical elements entering into the construction of the part invaded. In the larynx, absorption of the toxins does not take place readily; hence the main feature of the disease here is obstruction of the glottis, a purely mechanical condition. We believe the recognition of this fact early would lead to the more prompt adoption of the proper treatment for a mechanical obstruction. Primary laryngeal diphtheria is somewhat less contagious than throat diphtheria, probably due to the lesser malignancy of the bacillus. There does not seem to be a single good and sufficient reason, at the present time, for recognizing "membranous croup" as a separate and distinct affection. Dr. Raue evidently does not admit the existence of such, especially as he thinks the therapeutic test with antitoxin is positive, even in the absence of an affirmative bacteriological report. In regard to treatment, the author stands firmly for antitoxin. He would have us consider every suspicious case as one of diphtheria, so far as its therapeutics are concerned. He asks us to administer antitoxin at once if there be an abundance of membrane that is spreading or any laryngeal involvement. This would seem to be good advice, if we may believe that antitoxin serum is absolutely harmless. But Dr. Raue is not, by any means, willing to give up his homœopathic medicaments. He claims for them a place in the therapeutics of this disease, which even antitoxin cannot usurp successfully. Antitoxin cannot control tissue changes, beyond preventing further damage by the toxins. He has some favorites among remedies. Experience has shown him that in *nasal* diphtheria *kali bichromicum* 2x and *hepar* 3x are most useful. If he had omitted *arum triphyllum*, it would have been unfortunate. He finds this remedy best when the nasal discharge is excoriating, and the little patient picks its nose and *lips* until they bleed. When the disease invades the larynx, then *merc. cyanatus* and *kali bichromicum* are especially useful. In septic cases, *lachesis* and *arsenic* and *liq. calcis chlor.* are recommended. In profound heart weakness, *strychnia* and *alcohol* are called for; and, even early, the heart must be judiciously stimulated. We would like to

add that, especially are heart stimulants called for in cases to which large doses of antitoxin have been administered. This is a clinical fact that may be confirmed, although we are not prepared to point out any causal relationship between the two. The recommendation of local treatment of the throat by permanganate of potash, 1-1000, is of doubtful utility. Dioxide of hydrogen is, in our opinion, as good, if not better. The use, too, of this latter agent by atomization in the sick room is likely to remove bad odors, and seems to freshen the atmosphere. Altogether, Dr. Raue's paper would seem to show that the most efficacious treatment of diphtheria to-day is its treatment by antitoxin *plus* the homœopathic remedy indicated.

REMEDIES FOR PATCHED TONGUE.—Every physician knows how frequently the phenomenon of patched or mapped tongue is met with in practice. Dr. B. G. Clark has observed that all the cases presenting such a peculiarity have some *latent* or suppressed trouble, which mercurium or syphilinum, a few doses of the higher potencies at intervals of a week, will either develop or cause a train of symptoms that will clearly indicate the proper treatment. He mentions the case of a patient, aged eight years, who occasionally shows a mapped tongue, which only syphilinum cm. will clear up. This observation is valuable, as many patients habitually present such a tongue; and it is possible that in such cases the mercurium or syphilinum will clear up the cases after failure of other remedies. It is well to report such original observations.—*Homœopathic World*, London.

AN ECLECTIC IDEA OF THE TREATMENT OF ACUTE RHINITIS.—From the following remarks upon the treatment of that common affection, acute rhinitis, we may see that many of the prescriptions of our eclectic brethren are made according to the rule of similia. This fact will not trouble them, however, for they care less for theories than for results. We cannot help but admire their single-remedy prescriptions, as well as the clear-cut indications upon which the remedy is sometimes prescribed. If they would still more closely study the genus or individuality of their remedies, even better results could be obtained. When acute rhinitis is accompanied by fever, and the pulse is wiry and rapid, aconite is the remedy. When the pulse is full and bounding, veratrum will do better. When the nasal secretion is thin, watery and excoriating, liq. potassii arsenitis, in doses of one-third of a drop every two hours, is recommended. When the tonsils are enlarged and sore, and the lymphatic glands are also involved, phytolacca is preferable. Should there be a flushed face, contracted pupils, neuralgic pains in the frontal or supra-orbital region, then gelsemium would be indicated. A purulent secretion will require the sulphide of calcium, while a tough, tenacious and stringy secretion will yield quickly to the bichromate of potash. There are some cases of acute rhinitis in which a sensation of fullness in the nose provokes a disposition to blow that organ in an attempt to get rid of this feeling. However, no secretion is obtained. This is the condition calling for the administration of sticta, in doses of one-fifth of a drop. The reasons why these remedies prove curative in the conditions mentioned may be found by a study of their complete pathogeneses, to be found in any good homœopathic materia medica. But, after all, this is very amateurish homœopathy. Such prescriptions are like the pictures one takes with his first camera. Occasionally, a good one, but the majority—my, how they make one laugh, when he

knows better. These indications were taken from the very readable *Eclectic Medical Journal* for December.

PRESENT TENDENCIES.—Editorially speaking, the *New England Medical Gazette* deplores the fact, that while our friends of the old faith are steadily, though slowly, approaching simplicity in therapeutics and the single remedy, there seems to be undoubted evidence that some of the faithful in the homœopathic school are relapsing into the darkness and uncertainties of polypharmacy. A prominent homœopathic pharmacy has made the statement that of the yearly output of tablets for the past twelve months, 19 per cent. of those sold, or nearly that amount, were "combination tablets"—those containing more than one drug.

The editor concludes that the trouble is with the doctor, that he is either too busy or too lazy to study up the single indicated remedy in the majority of his cases. He exonerates the pharmacist from blame by saying that if there was no demand for the combinations they would not be manufactured. Now, in discussing this matter, we should not lose sight of the possibility that physicians prescribe remedies in combination because they are effective. If combination tablets did not cure that for which they were prescribed, it is impossible to believe that any sane-minded doctor would persist in using them year after year, as many do. The fact is patent that we of to-day are, as a sect, not as ardently devoted to the laws and tenets of homœopathy as were our forefathers. We guard less jealously the interests and progress of pure homœopathy—the science of medical therapeutics. True, we halloo loudly when our toes are tread upon; but it is more the scream of the American Eagle clamoring for rights of citizenship than the earnest protest of zealous homœopaths anxious for the steady growth and development of homœopathic therapeutics as a science. Our science must stand or fall upon a foundation of the proven drug and the single remedy. The man who cares a fig for the progress and growth of homœopathy will not use "combination tablets." Indifference in such important matters is at the bottom of all such slipshod therapeutic practices.

SEPTIC WOUNDS AND SINUSES.—Dr. Dean T. Smith, of Ann Arbor, thinks that there may be, perhaps, a happy mean between the extreme of lax old-style methods and the vigorous long-drawn-out methods practiced by some modern surgeons. After a wound is once made perfectly aseptic, it should be given a *chance* to heal. Strong antiseptics and rough handling injure the delicate granulations, and so retard the cicatrizing process. A man once came to this physician who had been treated for some time by another medical man for chancroids. He gave the patient some calendula cerate, with simple instructions to apply the same to the sores. Within a few days, healing was complete. Especially does Dr. Smith object to the *packing* of a cavity, such as we get in a wound or a sinus. The external opening should be kept patulous until the whole surface is aseptic. If, then, this condition can be maintained, and there is no foreign matter like dead bone or a diseased gland at the bottom of the sinus, it may be allowed to close as it pleases.

The author has seen a large number of sinuses and cavities that had remained, for a long time, almost stationary, but which quickly healed when the treatment was changed to simple surface-dressing. We can speak well of the healing properties of sterile watery solutions of calendula applied constantly.

to suppurating wounds and sinus. *Calendula* is scarcely appreciated as it should be.—*Medical Century*, March.

PEANUTS.—*The Medical Century* thinks that peanuts have the faculty of absorbing alcohol, and thus preventing it from demoralizing the nerves and upsetting the thinking machine. This is accomplished without entirely curtailing the exhilarating effects of the alcohol. A good wine-glass of olive oil has the same effect. Yet between "demoralized nerves" and peanuts washed down by olive oil there is little choice. Still, the suggestion may appeal to some,—most suggestions do.

PHASEOLUS NANA IN WEAK HEARTS.—Gradually there is accumulating clinical testimony favorable to the efficacy of this new remedy in certain manifestations of cardiac debility. Dr. Blackwood mentions a case in the January report of his interesting clinics. The patient was fifty-eight. He had worked very steadily, but his employment was confining. He was sparely nourished. For some five years he had been having "spells" in which there was a feeling of impending dissolution. Faintness with, at times, palpitation of the heart. Sometimes the action of the heart would be so feeble that its sounds could scarcely be detected. Pulse at such times very regular, but slow. Careful examination failed to show anything abnormal save this weakness of the heart. He was ordered to take more exercise in open air, and the *phaseolus 6x.* was administered three times daily. Great relief followed.—*The Clinique*. (Vol. 12, *Hom. Recorder*, contains some provings of the remedy, we believe.)

ARSENICUM IODATUM IN THE TREATMENT OF LUPUS.—Dr. H. Moeser, of Stuttgart, in *Hom. Monatshefte*, claims to have had considerable success in the treatment of lupus. He uses arsenicum iodat., second or third trituration. The following interesting case is mentioned in substantiation of his claims. A little girl of nine years had a face dreadfully disfigured by lupus. Her nose was partially eroded. General health much reduced, owing to her impoverished domestic surroundings. She received arsenicum iod. The disease was checked; the ulcerated places formed cicatrices so rapidly that she was dismissed as cured within four months. Four years later this patient was examined, and the disease had not returned. It must be mentioned that the doctor used in this case Kneipp's methods—baths and wrappings in wet sheets. However, the credit of the cure is given to the internal remedy. Dr. Moeser has had other experiences with the remedy as favorable as this.—*Hom. Recorder*, Jan. 15th.

HOW TO CURE DANDRUFF.—Isadore Dyer (in the *Med. Rev. of Reviews*) claims that this affection is very contagious, and that the hair-brush is largely responsible for its spread. He tells his patients to throw away their brushes. Then he has them wash the scalp frequently; as often as every other day in men, twice a week in women. After the wash, he applies resorcin in bay rum—three to five per cent. He has never seen a case of dandruff that did not get well under this treatment. In gray-haired individuals or in fair-haired women resorcin sometimes causes a yellowish or reddish cast, which may be prevented by adding salicylic acid to the resorcin solution.—*Maryland Med. Journal*.

THE THERAPEUTICS OF GASTRIC AFFECTIONS.—In an address on diseases of the stomach, before the Berlin Verein Homöopathischer Aerzte, June 13, 1901, Dr. Gisevius, Jr., gave the following therapeutics:

Supercidität (hyperchlorhydria).—Atropine sulph., third decimal trituration, several tablets before or after meals, or before retiring, in nocturnal attacks. It is not only a palliative, but may prove curative when there is underlying gout.

Anacardium, second decimal, is especially useful in topers; it may be alternated with *nux vomica*.

Lycopodium is an excellent remedy for gouty cases. The twentieth decimal is recommended. Associated symptoms are: turbid urine, fulness after eating (opposite to *nux vomica*), sallow complexion, emaciation.

Cocculus.—Flatulency, vomiting and nausea; waterbrash; suitable to women with amenorrhœa, backache, and occipital headache; neurasthenic males.

Argent. nitr.—Flatulency; sharp, stitching pains; feeling of coldness; dreamful sleep.

Phosphorus.—Heartburn; pain immediately after eating.

Ignatia.—Pressure at cardiac orifice of stomach after eating; relaxed feeling in stomach.

Carbo. veg.—Heartburn, foul eructations, extreme flatulency.

Hepar.—Sour taste; desire for spicy food. Especially in syphilitics who have taken too much mercury.

Iodine.—Ravenous appetite, but after the first mouthful the appetite is lost.

Gastralgia.—In this affection *bryonia* is a valuable remedy, being too often neglected.

Bismuth subnitr.—Waterbrash and diarrhœa, but this remedy has no particular disturbance of the gastric function in its symptomatology.

Arsenic and belladonna, sixth decimal, alternately, have frequently proven useful.

Atropine is also an important remedy in gastralgia.

Magnesia phosphorica, *dioscorea* and cyanide of zinc are doubtful remedies.

Dr. Gisevius then enters into an exhaustive study of *cuprum arsenicosum* in gastralgia. He was led to use this remedy from the symptoms recorded in the "Cyclopædia of Drug Pathogenesis." These provings are recited, but as they can be found in the original, it is unnecessary to quote them. The following clinical cases are reported:

1. *Gastralgia.* An officer, æt. 31 years, suffering for a long time with attacks of cardialgia, occurring periodically. He usually received narcotics, and of late hypodermatic injections of morphia were administered without much relief. The following symptoms were present: Indescribable and unbearable pain; continuous vomiting; the vomitus consists of yellowish-green fluid, which comes up in enormous quantities. Impossibility to take nourishment. The attacks lasted two to five days. After the attack he was obliged to diet himself carefully for several days. Physical examination of the stomach and clinical examination of the gastric contents, negative. During the first attacks arsenicum, belladonna and atropine were used, and with good

results. In the last attack they failed to give relief. *Cuprum arsenicosum* relieved the suffering promptly, and also cured the case. This is remarkable, in the face of the fact that morphine injections were entirely done away with.

2. An official, æt. 33 years, neurasthenic, suffering with cardialgia. The stomach does not tolerate ordinary food. Occasionally cramps occur. The patient has been a sufferer since 20 years. Formerly he obtained relief from bismuth subnitrate. Following a severe cold, acute gastritis developed, associated with renal colic. There is a violent pain, radiating from stomach to dorsal spine. All remedies seemed ineffectual until *cuprum arsenicosum* was tried, which cured the case.

3. Enteroptosis; floating kidney. A merchant, æt. 55 years, subject to recurring attacks of typhlitis, became ill with a violent attack of the same in December, 1900. There was high fever; dullness in the ileo-cæcal region; obstinate constipation. The peritoneum was highly irritated. The stools which eventually passed were lumpy and stained with greenish mucus. *Merc. sol.*, *bryonia* and opium were the remedies prescribed. Eight days following recovery he had a relapse. The attack recurred every eight days, with constipation and severe pains in the right hypochondrium. Palpation revealed a round, smooth, resisting tumor, which could be rolled up under the gall-bladder during respiratory movements (kidney). He had been struck in the right side of the abdomen several months prior. *Cuprum arsenicosum* was prescribed. The patient, who was completely emaciated and appeared a hopeless case, was entirely relieved of his pains, and made a full recovery.

4. Mrs. G., æt. 51 years. Has been in good health; ten weeks ago had great worry. Eight weeks ago intense pains in the abdomen set in, which were said to be due to flatulency by one physician and gall-stone colic by another one. They eventually subsided, after several weeks' treatment with morphia. Since fourteen days have recurred, coming on toward evening. They radiate from a point to the right of the umbilicus, toward the chest and back. Associated there is nausea and obstipation. The pains are very intense.

Physical examination reveals sound organs. In the right side of the abdomen, beside the umbilicus, there is a hard, sensitive, movable tumefaction, of the size of a fist. It does not move with the respiratory acts. *Plumbum 6* was given.

The next day the pain returned, and she took morphia. The following day the pain came as usual, and she was put on *cuprum arsenicosum*, fourth decimal trituration. The attack failed to return, and she has been free of the pain since that time.

In conclusion, Dr. Gisevius remarks on this case: It is noteworthy to observe the picture of a spasmodic contraction in a definite segment of the gut, simulating a solid tumor. The prompt cure following the use of the homœopathic remedy, as compared with the mere palliation by morphia, is most gratifying.

A CASE OF PSEUDO-ABDOMINAL TUBERCULOSIS.—Dr. Goullon (*Leipziger Populäre Zeitschrift für Homöopathia*, February, 1902), cites the case of an infant, 7 months old, suffering with vomiting, alternate diarrhœa and consti-

pation, and malnutrition. The condition had been diagnosed tuberculosis of the mesenteric glands, but Dr. Goullon questioned the diagnosis. Under a correction of the diet and calc. carb. a prompt cure followed.

INTERSTITIAL KERATITIS.—In the treatment of this disease we must rely on the indicated remedy. Such is the opinion of Dr. A. J. Forget, of Los Angeles, who, having practiced in the old school of medicine before studying homœopathy, has had ample opportunities for comparing the comparative efficiency of both treatments. He is satisfied that under the indicated homœopathic remedy the resorption of the opacities takes place more quickly and with less complication of the iris. We must, however, be careful to prescribe for the whole condition of our patient, rather than for the local eye disease. Dr. Forget thinks well of the use of atropine in these cases, and also praises warm compresses.

Among the remedies often indicated in interstitial keratitis, the doctor calls attention particularly to the following: Aurum mur., in the diffuse keratitis of syphilitic origin; mercurius biniodatus, when pain, ciliary injection and inflammation of the iris are present, with nocturnal aggravation. In cases presenting high fever, swelling of joints, etc., apis mel. will be likely to be the remedy. A dense infiltration of the cornea indicates either calcarea phos. or cannabis. We may distinguish between these two remedies by remembering that in the cannabis case the cornea is more vascular. After the inflammatory process has been allayed, hepar sulph. and sulphur are very useful in clearing up the cornea.—*Pacific Coast Journal*.

IRON IN MEDICINE.—Dr. A. W. Reddish thinks that iron, if given in material doses, must be regarded as a food rather than as a medicine, because it is uniformly found in the blood, tissues and secretions. By its administration hæmoglobin and the blood-corpuscles are increased. The author also believes that iron is undoubtedly the chief remedy in chlorosis, an opinion that we would willingly share were it not for the fact that iron cures fewer cases of chlorosis for us than several other remedies. We may recognize the need for this remedy when the cheeks of our patient are flushed, resembling the rosy bloom of health, but beneath this florid mask is concealed the veiled form of anæmia. During repose such a patient is apt to be pale and bloodless-looking. She has periodical headaches, worse after midnight, nose-bleed, and a disposition to uncover the chest, from an orgasm of blood in that region. The great indication for ferrum is in its power to dilate the blood-vessels, hence a full, soft pulse. The abdomen is sore. The chlorotic patient who requires iron is often a high school girl; she climbs long flights of stairs; she is listless, pale, earthy or green in complexion, and inclined to be quiet and silent. She eats chalk. Her catamenia is watery and scanty. Her mucous membranes are bloodless in appearance. Dr. Reddish thinks that such a girl needs teaspoonful doses of some easily assimilated preparation of iron as a food. Now, it is a curious coincidence, but nevertheless true, that a considerable number of young women present themselves at every homœopathic dispensary suffering from exactly this train of symptoms. Many of them have taken iron in large dosage for long periods, but yet have not recovered their health. Many of this class of girls are cured by pulsatilla, continued for months. So we have come to believe that the treatment of chlorotic girls by large doses of iron, as a food, is a delusion and a snare in many instances. Yet we may be in error, for experiences differ.—*Med. Century*, March.

THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER.

A Medical Newspaper.

EDITED BY

HERBERT P. LEOPOLD, M.D.

APRIL, 1902.

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A Practical Manual of Insanity. For the Student and General Practitioner. By Daniel R. Brower, A.M., M.D., LL.D., Professor of Nervous and Mental Diseases in Rush Medical College, in Affiliation with the University of Chicago, and in the Post-Graduate Medical School, Chicago; and Henry M. Bannister, A.M., M.D., formerly Senior Assistant Physician, Illinois Eastern Hospital for the Insane. Handsome octavo of 426 pages, with a large number of full-page inserts. Philadelphia and London: W. B. Saunders & Company. 1902. Cloth, \$3.00 net.

No graduate in medicine is thoroughly equipped to practice his profession unless he be acquainted with at least the rudiments of the science of psychiatry. Broad though its domain and difficult of mastery, yet every one may readily acquire knowledge of those principles upon which depend a successful

treatment of those cases of mental disorder that form a part of every physician's practice.

It is the aim of this work to present to the medical student and the general practitioner the essential aspects of mental diseases as they have appeared to the authors. In doing this they have given an intelligent, up-to-date statement of the leading facts, and one that will be serviceable to those who may not have been able to give the subject exhaustive study. Inasmuch as the work is intended as a handy manual for students, elaborate case records and pathological details, as well as speculative and controverted questions, have been omitted. Special features making it more practical include the descriptions of those forms of insanity not usually observed in hospitals for the insane.

Morphinism and Narcomania from Opium, Cocain, Ether, Chloral, Chloroform, and other Narcotic Drugs ; also the Etiology, Treatment and Medico-Legal Relations. By T. D. Crothers, M.D., Superintendent of Walnut Lodge Hospital, Conn.; Professor of Mental and Nervous Diseases, New York School of Clinical Medicine, etc. Handsome 12mo. of 351 pages. Philadelphia and London: W. B. Saunders & Company. 1902. Cloth, \$2.00 net.

The alarming increase, in the last few years, of morphomania and the various associated narcomanias imperatively demands immediate attention by the medical profession. Every year the increasing prominence of this psychosis calls for more exact studies, with a fuller recognition of the condition and causes of the disease. Medico-legally, questions of responsibility have been asked with increasing frequency, and there has been no literature and no study of the subject to afford an intelligent answer until this present volume was initiated.

The special object of this work has been to group the general facts and outline some of the causes and symptoms common to most cases, and to suggest general methods of treatment and prevention. The object could not have been better accomplished. The work gives a general preliminary survey of this new field of psychopathy, and points out the possibilities from a larger and more accurate knowledge, and so indicates degrees of curability at present unknown. The author shows his absolute familiarity with his subject in the clear, concise, and in every way admirable work which he has given to the profession, whom he has placed under merited obligations.

Saunders' American Year-Book.—The American Year-Book of Medicine and Surgery for 1902.—A Yearly Digest of Scientific Progress and Authoritative Opinion in all branches of Medicine and Surgery, drawn from journals, monographs, and text-books of the leading American and foreign authors and investigators. Arranged, with critical editorial comments, by eminent American specialists, under the editorial charge of George M. Gould, A.M., M.D. In two volumes—Volume I., including General Medicine, octavo, 700 pages, illustrated; Volume II., General Surgery, octavo, 684 pages, illustrated. Philadelphia and London: W. B. Saunders & Co. 1902. Per volume, cloth, \$3.00 net; half morocco, \$3.75 net.

The plan of issuing the Year-Book in two volumes, inaugurated two years ago, met with such general favor with the profession that the publishers have decided to follow the same plan with all succeeding issues. Each volume is complete in itself, and the work is sold either separately or in sets.

The contents of these volumes, critically selected from leading journals, monographs and text-books, is more than a compilation of data. The extracts are carefully edited and commented upon by eminent specialists, the reader thus obtaining not only a yearly digest of scientific progress and authoritative opin-

ion in all branches of medicine and surgery, but also the invaluable annotations and criticisms of the editors, all leaders in their several specialties. As usual, this issue of the Year-Book is not lacking in its illustrative feature; for, besides a large number of text-cuts, the Surgery volume contains five, and the Medicine volume four, full-page inserts. In every way the Year-book of 1902 upholds, if it does not strengthen, the reputation won by its predecessors.

Clinical Hæmatology.—A Practical Guide to the Examination of the Blood with Reference to Diagnosis. By J. C. DaCosta, Jr., M.D., Assistant Demonstrator of Clinical Medicine, Jefferson Medical College; Hæmatologist to the German Hospital, etc. Containing eight full-page colored plates, three charts, and forty-eight other illustrations. Philadelphia: P. Blakiston's Son & Co. 1901. Price, \$5.00.

Of all the subjects pertaining to clinical laboratory work, the examination of fresh and dried blood specimens is at present exciting the most interest. The recent discoveries of hæmatologists have attached to the subject the highest practical importance. It will not do for the physician to remain in ignorance of the subject while he delegates his blood examinations to a specialist, but he must make the investigations for himself.

It is not surprising, therefore, that medical literature has been enriched by several works on blood examinations, and the significance of blood changes following each other at short intervals. DaCosta's Clinical Hæmatology is the latest of these, and presents all the practical data in a clear and concise manner. As the author states in his preface, the work is "designed as a practical guide to the examination of the blood by methods adapted to routine clinical work, represents as an endeavor to recount the salient facts of hæmatology as they are understood at the present time, to correlate certain of these facts with familiar pictures of disease, and to apply them to medical and surgical diagnosis."

The author's style is eminently practical. Theoretical discussion has been introduced at times, but never in excess of the demands of a practical working knowledge. While numerous methods of examination are fully described, the reader is never left in doubt as to the author's opinion as to the best for the practitioner's every-day use.

We have perused the volume thoroughly, and are greatly pleased with the author's clearness of diction,—so clear, indeed, that the novice may accept "Clinical Hæmatology" as a reliable and efficient tutor. The fact that the book is a complete treatise need not awe him with the wealth of information imparted in its pages, for the marginal annotations designating the subject-matter of the various paragraphs enable one, by the aid of the index, to obtain information on its subject connected with hæmatology almost in an instant.

The mechanical workmanship of the book is all that can be desired.

Ophthalmic Diseases and Therapeutics. By A. B. Norton, M.D., Professor of Ophthalmology in the College of the New York Ophthalmic Hospital; Oculist to the Hahnemann Hospital, and to the Laura Franklin Free Hospital for Children; President of the American Institute of Homœopathy; Ex-President of the American Homœopathic Ophthalmological, Otological and Laryngological Society, etc. With ninety illustrations and eighteen chromo-lithographic figures. Third edition, revised and enlarged. Philadelphia: Boericke & Tafel. 1902.

The call for a third edition of this standard work so soon after the appearance of the second edition is highly creditable to the author. True it is, that the book is without a competitor as a complete ophthalmic text-book for the homœopathic school; but if it were devoid of merit, candidates designed to displace it from its high position would soon appear.

Among the improvements to be noted in the present edition is a clinical index or repertory, which has been prepared by Dr. Edwin S. Munson, for a number of years collaborator of the New York Materia Medica Society, and for six years assistant surgeon to the New York Ophthalmic Hospital. This clinical index has been condensed to what may be considered absolutely reliable keynotes.

The book has been well printed on good paper. We are sorry that the binding is not such as to commend itself to the lover of the beautiful. It is true that a pretty girl can stand a poor dress, but she will look more handsome if she is tastefully clad.

Nursing; General, Medical and Surgical, with Appendix on Sick-Room Cookery. By Wilfred J. Hadley, M.D., F.R.S.P., F.R.C.S., etc., Physician and Pathologist to the London Hospital; Lecturer to Nurses at the London Hospital Nursing School; Assistant Physician to the Chest Hospital, Victoria Park. Philadelphia: P. Blakiston's Son & Co. 1902.

Nursing manuals have more than a passing interest to the practitioner, as by their perusal only can he become acquainted with the ideas taught nurses in the training schools; and by acquaintance with them only can he judge of their attainments. The present volume is from the pen of a man who has had practical experience in the education of nurses, and it is the result of his lectures to the nurses at the London Hospital, amplified by experiences and observations respecting the virtues and weaknesses of those of whom nurses are made.

The first three chapters deal with general matters relating to the sick-room. Then follow the special subjects of medical and surgical nursing. Care is observed to tell the reader what the nurse should observe, and the demands of the patient under varying conditions. The author has been successful in his effort to make the work a practical one.

International Homœopathic Directory. 1902. London: Homœopathic Publishing Co. 1902. Price, \$1.00.

So far as the homœopathic practitioners of Great Britain and dependencies are concerned, this little book is a complete directory. As for additional names from other countries, they have been admitted on the basis of being able to part with one dollar, rather than for their special merits or prominence. So far as foreigners are concerned, the printing of such names is self-advertising, pure and simple. We do not approve of such business ventures.

A Compend of General Pathology. By Alfred Edward Thayer, M.D., Assistant Instructor in Gross Pathology, Cornell Medical College; Pathologist to the City Hospital, etc. Containing 78 illustrations, several of which are printed in colors. Philadelphia: P. Blakiston's Son & Co. 1902. Price, \$1.00.

In preparing this compend, the practical needs of the student have been considered, controversial matter and references to authors and articles have therefore been omitted, and the effort to simplify the subject steadily maintained. Chapter VI., on Inflammation and Repair, is based almost entirely upon a syllabus prepared by Prof. James Ewing, of Cornell Medical College, for one of his classes. To Dr. John C. Johnston the author expresses his indebtedness for valuable hints, and for the photographs which illustrate the chapter on neoplasms.

Syphilis: A Symposium. E. B. Treat & Co., New York. 1902. Price, \$1.00.

This embraces a series of essays on important facts relating to syphilis by eminent specialists, as Robin, Fournier, Gottheil, Gwyn, Buckley, and others.

The final pages of the work are devoted to answers by prominent authorities to the following questions:

1. What is the safest course in the diagnosis of syphilis?
2. Has the range of remedies in syphilis increased in recent years?
3. What is your opinion as to the secondary period of syphilis having been skipped in cases which develop severe tertiary lesions without a history of precedent active syphilis?
4. In how far should the physician assume the responsibility in sanctioning matrimony in syphilites?
5. What is your opinion as to the transmissibility of syphilis in the progeny of a tertiary syphilitic?
6. Do you know of any case in which unequivocally syphilitic fathers have procreated children who have remained healthy?

These questions are answered by Drs. Louis A. Duhring, G. Frank Lydston, Orville Horwitz, Thos. G. Morton and Edward L. Keyes.

The sphere of the work, as well outlined, gives a correct idea of its scope. It is concisely written, and is practical. Some of its chapters relate to subjects not usually considered, *e.g.*, that on syphilis of the stomach, by Dr. Boardman Reed.

Warwick of the Knobs. By John Uri Lloyd, author of "Stringtown on the Pike," "Etidorpha," "The Right Side of the Car," etc. New York: Dodd, Mead & Co.

Having gained high reputation as a pharmacist, John Uri Lloyd, of Cincinnati, has followed in the footsteps of other successful professional men, and in these later years has turned his attention to letters.

In the hills which he knew in boyhood days, and which he can almost see as he glances across the river from his Cincinnati home, he has found characters and scenes new to the reading public, and in this, the latest of his Stringtown novels, he has attained a strength of character-painting which places him among the first of the large group of native novelists that have in a few years contributed so much to American literature.

His story is not a pleasant one. It deals with Preacher Warwick, a cold, harsh exponent of the beliefs of the old school of Baptists. By his intolerance of all pleasures, his inhuman detestation of all the joys of life, he utterly forfeits the reader's sympathy. The catastrophe of his daughter's betrayal, the failure of his son to wreak vengeance on the guilty man—all these are told, and told well. At the end, however, the reader puts the book aside without regret, for the story is but a grim tragedy—a tragedy of souls.

The book is charmingly illustrated with photographs of the picturesque "knob" country which lies along the Ohio river on the Kentucky side.

New York Letter.—The New York Homœopathic Materia Medica Society met at the residence of Dr. Walter Sands Mills, 154 West 119th Street, on the evening of February 19th. Verifications were reported by Drs. B. G. Clark, W. I. Pierce, J. Hutchinson and E. D. Simpson. There was much discussion of each case in turn, and the meeting was a very profitable one.

The regular meeting of the Academy of Pathological Science was held on Friday evening, February 28, 1902, at 8.30 o'clock, at the residence of Dr. A. W. Palmer, 210 West 57th Street. The following were elected to membership: Dr. W. H. Dieffenback, Broadway and 56th Street; Dr. B. B. Clark, 171 West 129th Street; Dr. W. B. House, 218 West 112th Street; Dr. J. K. Weatherby, Montclair, N. J.; Dr. Merritt I. Beers, Metropolitan Hospital; Dr. S. B. Moore, Metropolitan Hospital; Dr. Garcia Leao, 234 East 86th Street. The following program was presented: Dr. John Hutchinson, Communication supplementary to Dr. Simpson's demonstration of suggestion. Dr. Hugh Kidder, Larva of fly or beetle, said to have been passed from bowels.

Dr. A. W. Palmer, Demonstration of tonsillar hypertrophies; living subjects. Dr. Irving Townsend, Malignant tumor of throat; living subject. Dr. Geo. W. Roberts, Calculous nephritis, nephrectomy. Dr. E. G. Tuttle, Sarcoma of puerperal uterus; septicæmia; hysterectomy; sac of inguinal hernia, with congenital absence of testicle; tubercular testicle. Dr. Geo. F. Laidlaw, Carcinoma of breast; direct extension to lung and bronchial glands, with multiple metastases in the viscera; axillary glands unaffected. Atelectasis pulmonum from child six weeks old. Secondary pneumonia, nephritic, in puerperium, simulating puerperal fever; meningeal œdema; same case. Disseminated tubercular pneumonia and meningitis.

The County Society met March 13th. Dr. Edward R. Snader, of Philadelphia, presented a paper on "Diagnosis of Empyema." The treatment, surgical and medical, was thoroughly discussed by different members, among them Drs. Helmuth, Jr., Bishop, G. W. Roberts, J. E. Wilson, Edmund Carleton, S. F. Wilcox, and others. Quite a number of out-of-town men were present. At the February meeting a resolution was passed inviting homœopathic physicians within a radius of thirty or forty miles of New York to become corresponding members of the County Society. Many have taken advantage of the invitation.

Dr. C. S. Macy has resigned from the faculty of the New York Homœopathic Medical College.

Dr. Anson H. Bingham has been made anæsthetist to the Metropolitan Hospital. Drs. V. A. H. Cornell, W. M. Van Zandt and J. Ricardo have been appointed curators.

It is proposed to add three more men to the house-staff of the Metropolitan now, making fifteen in all.

The new tuberculosis pavilion is doing good work, nearly all the patients not in extremis improving some under the forced feeding and fresh air.

Dr. B. G. Carleton has a new edition of his *Uropoietic Diseases* in press.

Brooklyn Letter.—The 362d regular meeting of the Kings County Homœopathic Medical Society was held in Weed's Hall, corner of Bedford Avenue and Hancock Street, February 18, 1902, at 8.30 P.M. Attendance 45. The matter of refreshments and location of new meeting-place was upon motion left to the discretion of the Executive Committee as to details; the society having decided to have refreshments served after each meeting. Dr. Close then read a paper entitled "How to Make a Homœopathic Prescription."

Discussion.—Dr. Searle: The author seems to regard the homœopathic method as universal in application, and to ignore other fields of medical art where this method is not applicable. Granting that the homœopathic prescription is *summum bonum*, there are several obstacles to be overcome. The materia medica is not impeccable. We cannot depend upon the idiot, the ignorant or the delirious for a drug picture. Then comes the army of liars—many not intentionally so, but looking through "double-extra-million magnifying spectacles," so you cannot believe anything they say. Now let us take a broad view of the whole field of medicine, where the homœopathic prescription is not applicable: Surgical operations: Reflex diseases: Parasitic diseases: Obstetrical incidents: The uses of eserine and atropine: Anodynes: Emetics: The uses of quinine: The local treatment of gonorrhœa, sunstroke, etc. The author evidently is looking for a renaissance of the Hahnemannian homœopathy, I believe he will be disappointed. My own belief is that what is true and practicable of the homœopathic method is held to-day as strongly as ever, and practiced as efficiently. One thing more: I am surprised that the author repudiates keynote; many are false, but others are not to be dispensed with.

Dr. Pierron : I do not believe that the exhaustive method of the author can be used at all times by the busy man. Certainly I could not devote so much time to one patient.

Dr. Moffat, the Necrologist, read a report on the death of Dr. C. L. Bonnell.

Drs. Ritch, Chapin, Baker and Kéep spoke in highest terms of the deceased.

The staff of the Brooklyn Maternity, which has become a general hospital, has been increased by the addition of Dr. Winchell, as nose and throat specialist, Dr. Aten, Neurologist. Dr. H. C. Allen has been elected a regular member of the staff, taking the place left vacant by the death of Dr. Doty. Dr. R. I. Lloyd was elected Pathologist.

Meeting was postponed to avoid conflict with State Society dates.

R. I. Lloyd, M.D.

For Sale.—A physician's residence, including practice, established twenty-two years. Fourteen-room house in northern central part of Philadelphia, with nicely situated offices. Reason for selling, desires to retire. Address "W. P.," office of HAHNEMANNIAN MONTHLY.

For Sale.—A physician's house, including most of his practice, amounting to thirty-five hundred dollars yearly, in a borough of 1000 inhabitants, located within twenty miles of Philadelphia, and a prosperous farming district surrounding. Address "T. S. W.," care HAHNEMANNIAN MONTHLY, 1506 Arch Street, Philadelphia.

Personals.—Dr. Frank L. Hughes, Hahnemann, '98, is located at 1509 North Sixth Street, Philadelphia. He is paying special attention to anæsthesia.

Dr. Ch. Gatchell has a new work in press on "Diseases of the Lungs : their Pathology, Symptomatology, Diagnosis and Treatment." The book will be issued in a few weeks.

The firm of Boericke & Runyon announce there will be a third edition, enlarged and revised, of Dr. Carleton's book on "Uropoietic Diseases," ready in one month. The book will be thoroughly up to date on diseases of the kidney and bladder, and with their latest surgical, general medical, and homœopathic treatment. The book consists of 400 pages. Price, \$3.50.

Deaths.—The funeral of Dr. I. D. Foulon, of 531 Brighton Place, St. Louis, took place March 8th from the family residence to Mount Hope Cemetery. The body was taken to the First Baptist Church, where Rev. Dr. A. L. Jordan conducted the religious services. Dr. Foulon leaves a widow and one daughter, Miss Lillian Foulon. He was born October 16, 1849, at La Fere, France, and came to America with his parents in 1858. He entered Shurtleff College, at Upper Alton, and graduated from the institution with high honors in 1870. In 1872 he accepted the chair of Latin in the Illinois University at Champaign. Afterwards he entered the St. Louis Law School, and, after securing a diploma and license, practiced his profession for a time in St. Louis.

Dr. Foulon, however, was not satisfied with the profession of law, although he gained considerable prominence as a member of the St. Louis bar. He believed that he was better adapted to the medical profession, and in 1876 he abandoned law and took up the study of medicine. He graduated from the Homœopathic Medical College of Missouri, and immediately took up the practice. Dr. Foulon was a writer of considerable prominence. He was the editor of Kunkel's *Musical Review*, and also of the French weekly, *La Patriote*. At

the time of his death he was President of the Alumni Association of Shurtleff College. He married Miss Henrietta Bradley, of Champaign, Ill., in 1878. Dr. Foulon was a member of the Board of Education of East St. Louis for three years.

Dr. Peter Cooper, formerly of Wilmington, Del., died at Blue Bell Copper Mines, Arizona, from hæmorrhage. He went West two years ago for his health, being a sufferer from consumption. Dr. Cooper was forty-four years old, was a native of Kent county, Del., graduated from Hahnemann College, Philadelphia, and practiced for a time at Chestertown, Md. In Wilmington he built up a large practice, making a specialty of diseases of the eye, ear and throat. He leaves a widow and five children. He was President of the Delaware Beneficial Society and was a member of the Masonic fraternity.

Dr. George Titman died January 24, 1902, at Hackettstown, N. J., from bowel obstruction.

Dr. J. Keasbey Weatherby, Hahnemann '00, has located in Haddonfield, N. J., taking the practice of Dr. Bowman H. Shires, who died lately of pneumonia.

Announcement.—The Seventh Post-Graduate Course in Orificial Surgery, by E. H. Pratt, M.D., will be held in the amphitheatre of the Chicago Homœopathic Medical College, corner Wood and York Streets, Chicago, Ill., during the week beginning with April 28, 1902, having a four hours' daily session. Doctors are invited to bring obstinate cases of every variety of chronic disease.

For particulars address

100 State Street, Suite 1203.

E. H. Pratt, M.D.,
Chicago, Ill.

Resolutions Passed by the Indianapolis Homœopathic Medical Society upon the Death of its Oldest Member, Dr. J. R. Haynes.

Whereas, It has pleased an all-wise Providence to remove from our midst, by the hand of Death, our beloved fellow-member, Dr. John R. Haynes, and

Whereas, His loss is particularly felt by reason of his long and intimate association with this Society and his unfaltering devotion to his chosen profession, be it

Resolved, That the Indianapolis Medical Society hereby expresses its profound regret at the sad calamity which has taken him from among us, and extends to his family its deepest sympathy.

W. R. Stewart,
C. B. McCulloch,
Committee.

A. A. Ogle,
President.
W. E. George,
Secretary.

Class of '77, New York Homœopathic Medical College and Hospital.—Each member is urged to be in attendance Alumni Day, May 8th, for auld lang syne. Come and renew old friendships and memories; note the improvements in the college; attend the valuable and interesting clinics in the morning, commencement in the afternoon, and in the evening, at Delmonico's, the banquet, which promises to be the most enjoyable of the quarter century. Those who are not members of the Alumni Association should join it now, and help plan and carry into effect means of making it more interesting, active and useful than ever, even if they find it impossible to be present this time.

John L. Moffat, M.D., '77.

Alumni Day at the New York Homœopathic College and Hospital.—The celebration of Alumni Day at this institution will take place May 8th, at 10 o'clock A.M., at the College Building, corner Sixty-third Street and Avenue A. The ceremonies will commence with a few words of welcome from

the Dean, which will be followed by lectures, demonstrations and operations by members of the Alumni. It is expected that these lectures will possess great interest, as the gentlemen selected are celebrated in the specialties on which they are to speak. It is hoped that every alumnus will make the endeavor to be present on this occasion, as it promises to be a most instructive and interesting occasion.

The Local Committee of the American Institute.—All arrangements are rapidly completing for making the meetings of the American Institute of Homœopathy in Cleveland a success long to be remembered. The local profession welcomes every member, and promises that in the matter of hotels, railways, entertainments and the like, no disappointment will be experienced. Every promise heretofore made will be fulfilled. One of the principal features of the week's meeting will be the coming together of the various college alumnae, forming a grand College Alumni Association, who will have special rooms assigned them in the Hollenden Hotel, and, on one evening, be given the large Assembly Room in the hotel for the "round up" with general jollification, music, singing and speeches. On another evening a reception, ball, and banquet, will be given at the Colonial Club on Euclid Avenue. The usual first night opening services, addresses of welcome, President's Address, etc., will be held in the Chamber of Commerce Building, where all the meetings of the Institute will be held. The Memorial Exercises are also suitably provided for.

On Saturday the Erie Railway has tendered an excursion to Cambridge Springs, Pennsylvania, where the visitors will be the guests of the Hotel Rider. During June, Cleveland is famed for its beautiful weather and its cool sleeping nights. It is justly called the "Forest City," with its miles and miles of paved and shaded streets, for driving, walking and bicycling—a boulevard system connecting its many beautiful parks and waterways, and an unparalleled system of trolley lines. The meeting-place and the hotels are adjacent and in the very heart of the city, accessible to the railways, places of amusement, the principal stores, and points of interest. A cordial and most hearty welcome is extended to every homœopathic physician—and his wife—to meet in Cleveland, this summer, with the American Institute of Homœopathy.

Gaius J. Jones, M.D.,

(Chairman Local Committee.)

The New Haven (Conn.) Homœopathic Clinical Society.—The Homœopathic Clinical Society convenes at Grace Hospital the first Thursday evening of every month. The officers are: Dr. Paul C. Skiff, *President*; Dr. Charles Vishno, *Vice-President*; Dr. Henry P. Sage, *Secretary*; *Censors*, Dr. Adelaide Lambert, Dr. U. Woods and Dr. John A. Hutchinson.

This year the officers will be: Dr. Charles Vishno, *President*; Dr. Emory J. Walker, *Vice-President*; and Dr. Henry P. Sage, *Secretary*. Names of members: Berdett S. Adams, M.D.; Marshall Jewell Adams, M.D.; Wm. P. Baldwin, M.D.; W. E. Butler, M.D.; Arthur S. Cheney, M.D.; Benjamin H. Cheney, M.D.; C. A. Darman, M.D.; Edwin C. M. Hall, M.D.; Adelaide Lambert, M.D.; Henry P. Sage, M.D.; Wm. H. Sage, M.D.; Paul C. Skiff, M.D.; Walter C. Skiff, M.D.; Chas. Vishno, M.D.; Charles W. Vishno, M.D.; E. J. Walker, M.D.; Jarvis U. Woods, M.D.; John A. Hutchinson, M.D.; Robert J. Ferguson, M.D.; George E. Evans, M.D.; B. A. Sawtelle, M.D.; Mrs. H. G. Newton, M.D.

Metropolitan Hospital, New York City.—The annual competitive examination for Interne in this hospital will be held at 75 W. Fiftieth Street, at 2 and 8 P.M., May 2, 1902. The hospital offers unusual opportunities for

perfection in the arts of physical examination, general medicine, surgery and pathology. There will be seventeen vacancies—three to be filled at once, five on June 1, and the remainder on completion of the building, December 1, 1902. The term of service varies from a year to eighteen months, choice depending upon the examination.

With letter requesting entrance to the examination, a letter of endorsement from the secretary of your college faculty and two from business men will be required.

B. G. Carleton, M.D.,

Chairman Committee on Examinations.

Minnesota Institute of Homœopathy.—The following is a list of the various chairmen of the bureaus to be discussed at the forthcoming meeting of the Minnesota Institute of Homœopathy, which meets May 21–23 next:

1. Electro-Therapeutics, Bessie P. Haines, Minneapolis.
2. Skin and Venereal Diseases, P. A. Higbee, Minneapolis.
3. Medical Jurisprudence, Mr. Bannon, St. Paul.
4. Anatomy, Pathology and Histology, A. E. Comstock, St. Paul.
5. Clinical Medicine, O. H. Hall, St. Paul.
6. Obstetrics, B. H. Ogden, St. Paul.
7. Materia Medica, G. E. Clark, Stillwater.
8. Sanitary Science, Henry Hutchinson, St. Paul.
9. Science of Homœopathy, Thos. Lowe, Slayton, Minnesota.
10. Surgery, W. S. Briggs, St. Paul, Minnesota.
11. Gynæcology, Cora Smith Eaton, Minneapolis, Minn.
12. Mental and Nervous Diseases, Henry M. Pollock, Fergus Falls.
13. Diseases of Children, L. E. Penney, St. Paul, Minn.
14. Eye, Ear, Nose and Throat, E. L. Mann, St. Paul, Minn.

Illinois Homœopathic Medical Association.—The Illinois Homœopathic Medical Association will meet in Chicago, May 13th, 14th and 15th, on the seventeenth floor of the Masonic Temple. A banquet will be given Wednesday evening at the Auditorium Hotel to the visiting members outside of Cook county, by the resident physicians.

Annual Reunion of the Alumni Association of Hahnemann Medical College, Philadelphia, Thursday, May 15, 1902.—The annual reunion and banquet of the Alumni Association of the Hahnemann Medical College, Philadelphia, will be held on Thursday, May 15, 1902.

The Business Meeting will convene at 4.30 P.M. in Alumni Hall, Hahnemann Medical College, Broad Street, above Race, Philadelphia, and the banquet will be held at 9.45 P.M. at Horticultural Hall, Broad Street, above Spruce.

The Trustees and Faculty of the College extend a cordial invitation to all the members of the Alumni and their friends to attend the Fifty-fourth Annual Commencement, to be held on the same evening, at 8 o'clock, at the Academy of Music, S. W. corner Broad and Locust Streets, Philadelphia.

Banquet cards can be secured by notifying the Secretary. Requests received after Wednesday, May 14th, cannot be considered.

W. D. Carter, M.D., '94,

Secretary.

1533 South Fifteenth Street.

Officers: *President*, Alonzo P. Williamson, M.D., '76, Minneapolis, Minn. *Vice-Presidents*, Charles L. Rumsey, M.D., '90, Baltimore, Md.; R. F. Heilner, M.D., '87, Scranton, Pa.; Chandler Weaver, M.D., '79, Foxchase, Pa. *Treasurer*, William H. Keim, M.D., '71, Philadelphia. *Permanent Secretary*, Woodward D. Carter, M.D., '94, Philadelphia. *Provisional Secretary*, D. Bushrod James, M.D., '96, Philadelphia. *Necrologist*, L. Willard Reading, M.D., '80, Philadelphia. *Executive Committee*—One year: W. W. Van Baun, M.D., '80, Philadelphia; Joseph C. Guernsey, M.D., '72, Philadelphia; J. W. Hassler, M.D., '92, Philadelphia. Two years: P. Sharples Hall, M.D., '91, Philadelphia; W. W. Speakman, M.D., '87, Philadelphia; John K.

Tretton, M.D., '88, Rochester, N. Y. Three years: George D. Woodward, M.D., '84, Camden, N. J.; O. S. Haines, M.D., '82, Philadelphia; H. B. Ware, M.D., '86, Scranton, Pa.

Ohio Valley Homœopathic Medical Society.—The regular meeting of the Ohio Valley Homœopathic Medical Society was held on Wednesday afternoon, March 12, 1902, at 2 P.M., eastern standard time, at the office of Drs. H. and A. A. Roberts, of Wellsburg, W. Va. The regular routine business was transacted, being followed by an interesting paper on "Obstetrics," by Dr. Jeannette Erskine, of Steubenville, Ohio, which was discussed by the members present. Dr. W. B. McClure read a paper on "Gynecology." Dr. J. M. Fawcett, of Wheeling, W. Va., Dr. Fulton, of Steubenville, and Dr. A. C. Smith were asked to prepare papers for the next meeting.

The following physicians were present: Drs. Fulton, Erskine and Shane, of Steubenville, Ohio; Drs. H. and A. A. Roberts, of Wellsburg, W. Va.; Dr. A. C. Smith, of Mingo Junction; Dr. W. B. McClure, of Martin's Ferry; Dr. J. M. Fawcett, of Wheeling, W. Va., and Dr. W. N. Rogers, of Bellaire, Ohio.

The next meeting of the Society will be held in Wheeling, W. Va., in May.

Wm. N. Rogers, M.D.,

Secretary.

A New Use for X-Rays.—J. E. Gilman, Senior Professor of Materia Medica in the Hahnemann Medical College of Chicago, who through the agency of X-rays is said to have effected a permanent cure of cancer of the breast, says:

"I believe this treatment is an absolute cure for all forms of cancer. I do not know what its limitations are. In a particular case, the X-ray was applied every other day for a period of three months. At the expiration of that time she was cured absolutely. The application was by means of the regular Roentgen glass tube, which is attached to the wires of the battery. The tube lights up with a greenish light, and the ray is directed through the body of the cancer.

"The patient feels no sensation whatever, except of slight heat or cold, as the case may be. But the X-ray is merely one of the agents in the cure, merely an aid in the treatment. Not only cancer, but any other ailment of a similar nature can be cured by the method of treatment I use."

In explaining the particular function of the X-Ray, Dr. Gilman said: "The molecule of the human body is a cell, and all the tissues are made up of an aggregation of cells. The life-work of a cell is the taking up of its nutrition, the building up of its structure, the throwing off of the effete and worn-out particles. When these cells carry on this routine energetically, rapidly, and efficiently, the person is in the condition of absolute health.

"If any one of these three elements is imperfectly performed, there is a condition of disease. Nature is always trying to return to a normal standard. There are certain inorganic substances which enter into the composition of the human body or aid in carrying on its function, such as lime in the bones, and salt and iron in the blood.

"Now, there are two theories in relation to the formation of cancer. One is that a cancer is a germ, the other that there is some morbid principle which incites the growth of normal tissue in the wrong place. Both of these theories, I believe, are correct. The germ is present, and it is the germ that excites the abnormal growth of tissue. If I can destroy that germ, then I have simply the abnormal growth of tissue to deal with.

"And the growth being out of place, nature comes to my aid in its destruc-

tion. If I can furnish a nutrition for the cells, can force them to take it and can kill the germs, I have performed the task. The part the X-ray plays is, first, the destroying of the vitality of the germ; second, in stimulating the activity of glandular action and in cell transformation.

"The X-ray is a germicide. It is germicidal in liberating oxygen in the tissues and in forming ozone. It increases the vitality of the blood because it increases the red-blood corpuscles by stimulation. It increases the elimination of the worn-out particles. In some cases the effect of its application is almost immediate."

Novel Method for Removal of Tapeworm.—W. C. K., of Baltimore, Md., in *Medical Brief*, says: I beg to recite to you a story as told me by a neighbor. He is a high-toned, honorable gentleman, a Hollander.

"I was in Washington yesterday to see my son Henry. Several years ago he had a tapeworm. A doctor cured him at the time, so we thought, but it appears that the thing has grown again, and now he is going to try a doctor in Washington, who claims he can remove head and all. My daughter Dora has one, too.

"In Middleburg, Holland, there is a doctor named De Pu, who is a reckless chap. A friend of mine had a tapeworm. He called on Dr. De Pu. The doctor requested my friend to abstain from food of any kind for twenty-four hours, or until he got quite hungry. When he was so hungry that he felt as though he could not stand it any longer, the doctor fried a beefsteak, held it close to the patient's mouth, and, to my surprise, the patient began to gag, the worm stuck its head out of his mouth, and the doctor, with a scissors ready for it, clipped off the head, the balance receding. It was the last of it. *Upon my honor I saw this.* I requested Dora to let me do the same for her, but she will not submit to it."

The above seems incredible, but, considering the character of the friend referred to, I am obliged to believe it.—*American Homœopathist.*

[Our friend from Holland seems to have had a very bad ten minutes; but there is no really pure Holland Gin to be obtained nowadays; hence, one runs this risk whenever he takes a "Martini." (Suburban papers please copy.) Dora and Henry must watch Father, closely.]

The Old Guard.—The next annual meeting will be held in Chicago in June. "The membership shall include homœopathic physicians who have been graduates in medicine for thirty years. The oldest member present shall preside."

The object of this organization is to guard homœopathy and to advance the cause.

At the last meeting it was voted that each member should write out for publication, "How I Became a Homœopath," and send it to the Secretary. It was also decided that each member be requested to give his experience with our various remedies in the treatment of disease, according to similia, taking Jahr's "Forty Years' Practice" and Bayes's "Applied Homœopathy" as guides. These experiences are to be published, for the benefit of their less informed brethren, in such medical journals as the members may elect.

In reply to inquiries, it may be said that any earnest, reputable homœopathic physician, anywhere above the age limit, may apply for membership.

Yours for the cause,

President,
J. M. Gross, M.D. ('50),
Treasurer.

W. W. Estabrook, M.D. ('47),
Vice-President.
T. C. Duncan, M.D. ('66),
Secretary, 100 State St., Chicago.

THE HAHNEMANNIAN MONTHLY.

MAY, 1902.

THE RADICAL TREATMENT OF VARICOSE VEINS.

BY SIDNEY F. WILCOX, M.D., NEW YORK,

(A Clinical Lecture Delivered at the New York Medical College and Hospital for Women, reported stenographically by Miss Jane Sutherland, Editor of the *Crescent*.)

WE have to-day a case which, I think, will be of especial interest, because it is the first time we have had the opportunity of doing the new radical operation for varicose veins before this class.

I wish to call attention, first, to one thing in connection with the anæsthesia. On February 22d an article appeared in the *Medical Record* by the late Dr. Ralph J. Hess, a young surgeon connected with the Bellevue Hospital, who died before the publication of his article. It was on the avoidance of vomiting after anæsthesia. He stated that in most cases where patients were to be operated upon, cathartics were given and food and water withheld for some time previous to the operation. He concluded, from observation, that instead of withholding water before the operation, it was better to have the patient drink as much as possible, to hasten the elimination of ether afterwards by a free discharge of urine. This patient has been urged to drink as much water as possible, and we will observe the effects and report later.

Varicose veins are nothing more nor less than dilated and elongated veins, and may occur in various parts of the body. In the rectum they are known as hæmorrhoids; in other loca-

tions they may be known as varix, varicose aneurism, varicocele, and by other names, depending upon where they are. One of the most frequent locations is on the lower extremity, and consists of a dilatation of the internal saphenous vein and its branches. The deeper veins are not so likely to be affected, because they are surrounded and supported by the muscles, while the internal saphenous is only covered by skin and superficial fascia, and surrounded by fat, thus having very little lateral support. As the vein is fixed at two points, its beginning in the foot and its termination at the saphenous opening, if it becomes elongated, it can only do so by becoming tortuous. The vein also becomes enlarged in size by actual dilatation, this dilatation resulting partly from the lack of support to the walls and partly from the weakness of the wall, caused by paralysis of the *nervi vasorum*, or the nerves which affect the muscular tissue in the walls of the vein. The vein becomes enlarged, also, by pouching of certain portions of its wall; this is particularly true in the region of the valve. The valves of the internal saphenous vary in number from six to thirteen; and as the vessel dilates they lose their function, and sometimes, from the structural change which takes place in the vessel walls, they become shrunken and flattened against the wall of the vein. Thus the column of blood which should have received the support of the valve is only supported by the walls of the vein. This condition of the vein is not confined to the vessels of the leg alone, but may also occur in other portions of the body. There may also be a dilatation of the *vaso vasorum* or small vessels which run in the walls of the vein. These may become greatly dilated, so that they form pouches in the walls of the vein, which open into the veins themselves. Added to this, as a result of the constantly, retarded circulation, we have a certain amount of oozing of serum into the surrounding tissues and œdema. This is a chronic condition; and finally there occurs a deposit of fibrous material in the perivascular spaces, and a low type of tissue is formed, which is liable to break down on the slightest provocation, resulting in the formation of varicose ulcer. The causes of varicose veins are, first, a lack of support, weakness of the venous wall, the upright position of the patient, constricting garters or other bands about the limb, enlarged or gravid uterus, fibroid tumors, weak heart, etc.—any-

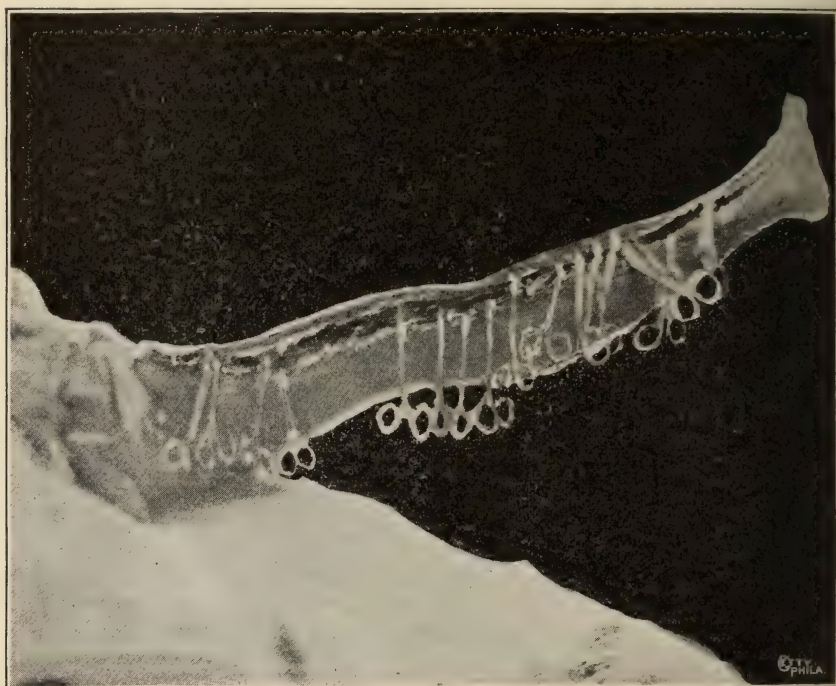
thing which passively or actively tends to obstruct or retard the flow of blood through the vein. Although this condition is more common among laboring people, it is not confined to that class; either men or women may be affected; and it is possible that some constitutional condition has something to do in predisposing to the formation of varicose veins.

Symptoms.—In the early stage the patient may suffer from pains around the knee-joint; later on the veins become visible, especially when the patient has stood for any length of time. They swell up, forming great corrugated blue welts, which gives rise to severe pain.

When the patient lies down, the effect of gravity is lost; the veins empty themselves, and there is no sign of dilatation. The varicose ulcers developed are very painful; they discharge a thin, sanious pus, and sometimes are very foul, and are accompanied by a considerable amount of inflammation. These ulcers are exceedingly difficult to heal up, because their development is favored by the upright position, and it is often difficult to keep the patient quiet sufficiently long to effect a cure.

Treatment.—The treatment of varicose veins may be divided into palliative and operative. The palliative treatment consists in giving support to the veins by means of bandages or rubber bands, or elastic stockings. The inunction of hamamelis cerate may give relief; but all of these palliative methods have little or no permanent effect. The operative methods which have been in vogue until within the last few years have been more or less disappointing in their results. These have consisted in ligating the veins at different points, removal of portions of veins, the injection into the perivascular tissue of certain substances, such as preparations of iron, tannin, ergotine, etc., with the idea of forming a clot and obliterating the vein. These latter methods are dangerous, as they are likely to result in the formation of a thrombus which may be carried to the lung and result fatally. The former methods are likely to be followed by disappointment on account of the free anastomosis of the vessels; so that, although one portion of the vein is cut off, a new channel is made around which joins the main trunk higher up, and really very little is effected. The late Dr. Samuel D. Gross, of Philadelphia, advised the use of Vienna

paste, which is a caustic preparation. He would take pieces about the size of a three-cent piece, but thicker, lay them on the skin, at points about five inches apart, along the course of the vein. These were allowed to remain in place for fifteen minutes; then they were removed, and the excess of alkali washed off with vinegar. The eschar was then poulticed until it separated. This caused an inflammatory action about the vein, which obliterated it in certain portions, but was attended with a very great deal of pain and tedious waiting.



With regard to the varicose ulcer, the only proper method is, first, to put the patient to bed, and then keep the leg elevated, so as to favor the return circulation. Various applications may be made to it, with the idea of causing granulation and cicatrization. Among these I have found one of the best to be ordinary brewers' yeast, which can be applied daily, and which stimulates or hastens healing by the presence of the nuclein which it contains. In the number of the *HAHEMANNIAN MONTHLY* which I received this morning, I find an article by Dr. Frank H. Pritchard, of Monroeville, O., in which he advo-

icates the use of hamamelis cerate in the treatment of varicose ulcers. The ulcer is first washed with a solution of soda, to remove all *débris* and extraneous matter; then the hamamelis cerate is plastered thickly over the sore, and upon this is bound an aseptically prepared sponge. The hamamelis stimulates healing, while the sponge soaks up all the discharges from the ulcer, thus assisting in the healing. The internal



administration of the same drug, at the same time, is advocated.

Radical Operation.—The operation which I am about to show you to-day has, so far as I know, only been employed for about a year, and the first mention I find of it is in an article in the *Medical Record* of December 29, 1900, by Dr. C. W. Borden of the United States Army. As it happened, I saw the article the evening before I was about to operate on a case at my clinic at the Flower Hospital, and the method as presented by the writer seemed so feasible and reasonable that I tried that, instead of the milder method, which I had intended to employ.

I have now performed the operation eight times at the Flower Hospital, and in all cases successfully, although some of them were accompanied by considerable suppuration, due to the inferior kind of tissue in which the operation was performed. Varicose ulcers should be healed before the operation; or, if small, they may be excised at the time.

Before this patient was brought downstairs I applied a bandage with moderate tightness about the thigh, high up, in order to retard the superficial circulation and distend the vein as much as possible; and while the distention has somewhat disappeared, owing to the bandage having slipped, still you can easily perceive the enlarged and tortuous condition of the vessel. Now, having rendered the skin as perfectly aseptic as possible, I make an incision longitudinally and directly over the vein, beginning at its upper end, being exceedingly careful to cut only down to the vein, and not into it. Sometimes, where there has been considerable inflammation, the walls of the vein are closely adherent to the skin, and unless great care is exercised, the knife will go directly into the vessel and there will be a sharp hæmorrhage. The vein should be separated from the surrounding fat by the knife and partly by dry dissection. This is usually easily effected, especially in the upper portion of the limb. Every bleeding-point should be caught by the artery forceps and tied, if necessary. In the upper portion of the leg we have very little difficulty with the branches, and very little blood will be lost; but with the very close network of veins in the leg and the adhesions which have been formed, the hæmorrhage is more difficult to avoid. It is that portion of the vein to which we are now coming, and we find that the vein is more adherent to the surrounding tissue, and that the dissection must be conducted with greater care. After the vessel has been located and uncovered, the constricting bandage should be removed, and then it will be found that a large number of the artery forceps can be taken off without very much bleeding. The large branches should be tied by two ligatures and cut between them. Here you see I have the vein dissected and lifted out of its bed, and only attached at its two ends. These I will now tie, and then cut away the vessel, which, now that the blood-pressure has been removed, dwindles down to a long, thin, hollow cylinder. We will now wash out the wound with a dash of bichloride solution or the normal

salt solution, and close it up. I am going to show this method of suturing, which is known as Abbey's buried suture, and which will not have to be removed. I will take a piece of cat-gut, and, putting in my first stitch about a half inch or more from the upper end of the wound, bring together the deep portions of the wound with an ordinary running suture. Carrying this down for about four or five inches, I tie a knot in the thread and stitch back, running just underneath the skin until I reach the point of beginning. Now I tie a knot with the original portion of the suture in such a way that it sinks underneath the skin, and when it is cut off short it disappears entirely into the tissues. This I continue to do the whole distance, uniting the wound in sections of about five inches long. Between the sections I insert a little piece of folded rubber tissue for a drain. This allows the escape of any blood or serum which may accumulate in the deep portion of the wound. Of course it is necessary to have the wound perfectly dry, if possible, and all bleeding should be thoroughly stopped before the stitching is begun; but often, in spite of the greatest care, there will be some oozing into the wound, which gives rise to trouble afterwards. Now that the wound has been thoroughly closed, I will apply over it narrow strips of rubber tissue, these strips being about three-quarters of an inch wide, and they effectually seal up the wound, so that there is very slight chance for any infection to take place. Over this we place short strips of oxide of zinc adhesive plaster, cross-wise. These serve to support the flaps of the wound, as well as to keep the rubber tissue in place. Over this we place dry gauze and sterilized cotton, which are held in place by an ordinary gauze roller. The patient will be kept in bed and her foot elevated, and the first dressing will be removed within the first week.

NOTE.—The technique of the operation was carried out exactly as described. In regard to the anæsthetic, the patient vomited a very little frothy mucus once after the operation.

The patient had only a slight rise of temperature following the operation, and suffered little pain. At the end of the sixth day the dressings were removed, and it was found that a little strip about four inches long had suffered from pressure necrosis, and had opened to that extent, but no harm was done, and the case proceeded rapidly to a cure.

SOME ELEMENTARY FACTS IN BACTERIOLOGY.

BY THEODORE J. GRAMM, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of Philadelphia County.)

THE study of bacteria is of very recent date. Until but a very few years ago there was no course in bacteriology in the curriculum of any college. It is not my object to draw invidious comparisons, but it is only necessary, in order to appreciate the import of this reference, to recall the teachings of surgery, and to remember their practical applications as we saw them exemplified in the clinical amphitheatre, not to speak of the results of surgical practice, if ever these were forcibly brought home to us. At that time the surgeon was much concerned about laudable pus and several other fallacies which the imperfect knowledge of the day forced upon him. And the peritoneal cavity—that *noli me tangere* of operative surgery—did we ever see that cavity designedly invaded? Contrast with the unclean procedures, the rude and almost primitive appliances, the misconceptions, the well-grounded fear of radical methods, and the bad results attending a major operation at that time, with the pronounced differences as exemplified in a properly organized surgical procedure, carried out in a well-appointed aseptic operating-room of the present day! And what has brought about this change? I need not point out that it depends almost entirely upon our knowledge concerning the lower forms of animal and vegetable life which are dealt with in the study of bacteriology. This study has revolutionized the practice of medicine, has altered our conceptions, has changed our entire point of view; it has essentially modified our approach to a case, especially surgical, and has transformed our results. All this is a matter of personal experience with most of us, for we have been present upon the scene of action to witness the transformation. We have beheld many medical matters, long enshrouded in the mystery and gloom of uncertain knowledge, emerge into the twilight of somewhat more certain information; and this advance, little as it is, is very great. But who that has followed these matters at all

would dare to think that we have reached the noontide of knowledge, and who will dare to predict what the next few years will reveal?

The idea of a living contagion had often been broached by a few of the pioneers in this untrodden region—as, for instance, by Kirchner two hundred years ago; but this conception was as often denounced and rejected by the majority, for they found themselves fortified by the ponderous and deadly influence associated with some of the names of those who stood high in the councils of the medical fraternity. Indeed, the essentials of a complete system—ay, verily! the essentials of the system which we practice to-day—had even been not only apprehended but promulgated by Semmelweis, for instance,—that magnificent observer, who was endowed with a keenness of perception which anticipated his times by fifty years. But because he could not furnish the reason in ocular demonstration, his brilliant inductions were reviled, regardless of their clinical proof. It is very instructive and would furnish considerable entertainment to trace the steps which led to our present state of knowledge in bacteriology, but the few moments which I am asked to occupy before you will not suffice even to mention them. Indeed, in an imperfect paper like this, the difficulty is not to determine what to say, but to decide as to what may safely be left unsaid. Consequently it is necessary to dispose of all the interesting matters associated with this point by saying that the study of bacteria dates from the time when Anthony van Leeuwenhoek ground his lenses and constructed his primitive microscope; and when, later, in 1675, he described minute organisms which he discovered in rain water, in infusions of pepper and hay and other animal and vegetable substances, and in the saliva. But the improved and perfected compound microscope, reinforced by the splendid experimental studies of later observers, were necessary before we found ourselves possessed of this wonderfully fascinating study of bacteria, as we now have it.

The almost infinitesimal forms of minute vegetable life spoken of as microbes, including bacteria and yeasts, have within the last twenty years assumed a great importance in our eyes, for we have learned that in many instances they are the causes of diseases, some of which are the most malignant

that affect the human race, and that they also infect our domestic and other animals with virulent disorders. The deterioration of many food-products and much of the laborious work required to preserve them for future use, together with decomposition in most of its forms, are ascribable to the action of microbes. We have therefore been induced to regard micro-organisms as our deadly enemies in some instances, and at all times our mysterious foes, against whom unceasing vigilance is the price of freedom not only from disease, but also from much inconvenience and economic loss. Now, while it is largely true that in some instances micro-organisms cause disease and entail much of the laborious work of every-day life, it is also true that bacteria are our most important coadjutors and friends. This is an aspect to which we may not have devoted so much attention. It is, however, a curious fact in Nature that these infinitesimal forms of life possess a vast, indeed an indispensable importance, for some of the most gigantic transformations upon the earth's surface have been brought about by these little things, which the unaided eye cannot appreciate. Here we behold an exemplification of the tremendous potentiality of small and apparently insignificant agencies.

Bacteria comprise a low form of plant-life, closely following the algæ. In outline they present three simple types, varieties of which may occur within narrow limits, namely, spheres, rods, and spirals. The more or less globular form is spoken of as the coccus, the small ones being called micrococcus. When two of them occur together, and retain this form habitually, they are spoken of as diplococci, as in the case of those causing gonorrhœa and pneumonia. The sarcina, found in the stomach, is an example of a group of four or more. One of the most common forms of cocci is the staphylococcus. Sometimes the cocci, in their growth by division, still adhere to the parent cell, and thus are formed long chains or filaments, of which the virulent streptococcus is an example. The rod form, of greater or less length, comprises many varieties, and is spoken of as a bacillus, of which the tubercle bacillus is a well-known example. In addition to these there is the spiral form, which exists with some modifications, as in the comma bacillus of Asiatic cholera. It is useless at present to mention the measurements of these bacteria, but if we wish to remember any

number, we may say that they are about one-twenty-five-thousandth part of an inch in diameter. The question was formerly much discussed whether these micro-organisms should be regarded as belonging to the animal or to the vegetable kingdom, since they possess characteristics common to both, the outcome of which is that they are forms of vegetable life. They are composed of a cell, having a wall containing cellulose, as may be shown by the action of iodine, which contracts the protoplasmic contents and renders the cell wall visible. This cell wall may be pliable, so that, if a long filament is formed, a slow vermicular motion is observable; or it may be rigid, so that the bacterium may retain a spiral form. The outer layer of the cell wall may form a transparent capsule, either from the absorption of water or in consequence of a secretion from the cell itself. This gelatinous material, when abundant, may form a transparent matrix in which large numbers of bacteria are grouped, when a zoogloea mass is spoken of. Of the internal structure it is not possible to speak with certainty, because their exceeding minuteness makes accurate observation quite difficult. Some bacteria possess very slender filamentous projections, single or multiple, protruding from one or both extremities, which are regarded as one of the means by which the active motions of some bacteria are effected.

The multiplication of bacteria is universally effected by fission or simple division. The parent cell increases in size, and soon a constriction is formed about its middle part which divides the parent into two equal halves; and this process is continued indefinitely and with great rapidity. This method of cell-division distinguishes bacteria from yeasts, which multiply by the process of budding, whereby a portion of the parent cell is extruded like a bud; and this portion, increasing in size, is ultimately separated, to lead an independent existence.

In addition to this method of growth, many bacteria possess the power of forming spores. These are highly refracting bodies, which develop in the middle or at one end of the bacterium, and increase at the expense of the parent, when endogenous spores are spoken of. Or the process may take place by a longer rod breaking up into several short, rounded elements, called arthrogenous spores. These spores have a far greater resistance to conditions adverse to the life of bacteria

than have the bacteria themselves. They withstand a greater amount of heat, desiccation, the action of chemical agents, and other adverse surroundings.

The rapidity with which bacteria are reproduced is one of their surprising characteristics, and is so great as to be almost incredible. While the minute size of bacteria might suggest their insignificance, their marvellous powers of rapid reproduction transform them into potent agents for good or evil. Some species that have been carefully studied have been observed to divide once in every thirty minutes or less. Thus it has been computed that in twenty-four hours one bacterium might produce 16,500,000, and in two days the number of bacteria is so great that they would fill a pint measure, and weigh about a pound. By this computation it is not intended to represent that anything like this ever actually takes place, for other circumstances intervene to prevent this occurrence, as, for instance, the lack of nutriment, and the important fact that bacteria excrete certain matters which are deleterious not only to their growth but also to their life. And yet these figures serve a purpose, for they permit us to form some conception of the wonderful potentiality of these small and apparently insignificant forms of life. Bacteria increase so rapidly because they live upon complex organic matter, which furnishes their nutriment without necessitating much elaboration on their part. It is not easy to classify these low forms of life, and it has therefore been found necessary to distinguish their shape, the manner of their multiplication, the formation of spores, and their general character respecting the shape of the colony growing upon nutrient media, their power of liquefying the same, whether growing best in the presence or absence of oxygen, and whether they are capable of producing disease. But a certain inherent peculiarity of bacteria has added difficulty to the matter. Under varying circumstances, certain characteristic qualities of some of the bacteria seem to be modified in several essential particulars. Bacteria may change their physiological character; they may, for instance, lose their power of producing disease. There is likewise observable, within certain limits, a change in their entire appearance. The same species may exist as a short rod or a thread, or break into spherical spores. Others may possess the power of motion, and at other times be stationary;

they are all exceedingly sensitive to temperature variations, and this exerts a material modifying influence. A way out of the difficulty is presented by using exactness in surrounding them with identical conditions while under observation.

Bacteria exist in the food we eat, in the water we drink, and in the air we breathe; but while the tissues of the normal body are probably free from them, yet they are abundantly present in the mouth, in the nose, and in the entire intestinal tract. The orifices of the body are their favorite dwelling-place. While the air on the highest mountains and in mid-ocean is theoretically free from them, yet they have been found even there. In nature, wherever heat, moisture and organic material are found, we may be pretty certain that bacteria exist. The universal presence of bacteria is not an insignificant, an independent, or even only a curious fact, for vast agencies are ascribable to their activity. It has long been known that wherever decomposition takes place bacteria are found, but it is only recently that we learned that decomposition is effected by means of micro-organisms. This fact alone has vast significance. If this be true, we must ascribe to their agency the circumstance that the surface of the earth is inhabitable. Think of the vast amount of vegetable matter which the earth has nourished during the ages past, all of which was destined to return to the earth which gave it life! In this connection it may be said that the extensive deposits of coal, upon which our present civilization is so dependent, was aided by bacterial instrumentality, as examination of the peat beds has disclosed. Then, again, try to imagine the inconceivably vast amount of animal matter which has played its little *rôle* upon the earth, even during man's brief residence here; all this, too, has disappeared, and the face of Nature greets us with a smile instead of with the hideous aspect which it might present. Bacteria have, therefore, acted as the scavengers of the earth's surface, which, but for them, would now be encumbered with the accumulated mass of animal and vegetable matters of past ages.

This phase of the subject, however, presents another interesting point of view; for bacterial activity plays an essential part in completing the circle through which chemical elements pass in their transition through the various kingdoms, from the mineral, through the vegetable and animal kingdoms, back

again to the mineral. The completion of fully one-half of this circle is directly ascribable to the agency of bacteria. In taking a hasty survey of this food circle, we find that the food which plants require is derived from the simpler chemical combinations of elements in the soil, and from the carbonic acid in the air, which is an excretion from animals. We will not pause to consider the action of bacteria in aiding the ultimate rootlets in obtaining these elements. But plants store within their tissues albuminous, starchy and fatty matters, which serve as food for the animal kingdom. In the course of their lives, animals exhale carbonic acid available for plant food. Nitrogenous foods obtained from plants are not returned to them as available plant food, neither when in the form of albumins stored in animal bodies nor in the excreted urea. The body of the animal, the urea, and the other animal excretions, except carbonic acid and water, must first be reduced to simpler combinations. At this point in the food circle bacteria play their indispensable part. Bacteria being universally present, and being ever ready, because of their innate qualities, to seize upon such complex organic compounds in the process which we have long known as decomposition, transform these materials into simpler forms; and this process, repeated in several stages by means of bacteria, terminates in the complete destruction of the animal body and of its excretions, whereby the several complex bodies do become plant food.

Bacteria play another important part. In the course of the processes just mentioned, it happens that a portion of the nitrogen is broken up into compounds too simple for plants to use, namely, into ammonia, which contains no oxygen, and into *nitrites*, which contain less oxygen than nitrates. Now, since the nitrogenous portion of plant foods is assimilated mostly in the form of nitrates, it is necessary that these products of decomposition must be oxidized, and this is effected by bacteria. There are also other bacteria which fix the free nitrogen of the air in the soil where they live, so that the soil gains in the amount of nitrogenous compounds. This is demonstrable, and can also be shown by appropriate experiments in the test-tube. Nitrogenous compounds are also added to the soil by means of bacteria acting in conjunction with the growth of certain plants of the legume family, to which belong the pea, bean and clover.

Nitrogen is found in the tubercles and roots of these plants, and these are eventually added to the soil. The value of green manuring by plowing under a crop of clover has long been practiced by farmers.

It is apparent from the preceding that bacteria have played a most important *rôle* in making the earth's surface inhabitable and in retaining the fertility of the soil, so that the circle of foods may pursue an uninterrupted course. The farmer is particularly dependent upon their action; indeed, his entire life, though he may not know it, is one continuous effort to foster the action of certain bacteria which favor his work, and to guard against the deleterious action of such bacteria as interfere with the success of his endeavors. Much of the laborious work of farming is ascribable to this cause. It may be said that the success of farming depends upon the intelligent use of bacterial activity. It is interesting to examine this matter in detail, but at present it is only possible to touch upon it in a most superficial manner. The farmer has long ago discovered that in bringing the products of his land to the markets of the city (where, by the way, we are throwing away vast sources of wealth by the present system of disposing of sewage), he is constantly diminishing the productivity of his soil, and in order to maintain this he is compelled to pay back to the land, by means of fertilizers, that which he takes from it in the shape of marketable crops. The compost-heap is therefore a most essential matter, as regards its size and quality. The fresh excreta of animals and all refuse animal and vegetable matter, all rich in nutritive material for plant life, are not in available form. It is first requisite that they shall be subjected to the elaboration of bacterial activity, and hence the endeavor is made to establish such conditions in the barnyard as will favor decomposition.

In the preservation of hay and fodder, and of all the grains, the processes employed have regard for the action of bacteria. A certain amount of drying and exposure to the action of the sun and air, after the crops have been cut, is necessary, to prevent their "heating" or fermentation in the mow or storehouse. The curing of tobacco is another instance, for it is believed that the manner in which this is accomplished determines much of the flavor of the finished product. The curing and smoking of beef and ham, the salting of pork, and the

charring or the application of preparations of creasote to the lower ends of fence-posts before placing them in the ground, are all processes intended to inhibit the deleterious action of bacteria. In the dairy, of all places on the farm, it is a question of the character of the bacteria present and the extent of their action; but the processes here are so well known and our time is so limited that we cannot even mention some curious questions which are under consideration by those intelligently interested.

In several other industries, some of which date from very ancient times, the action of bacteria is invoked. This is true of the manufacture of flax for linen, of hemp, jute, and cocoanut fibre. The crude materials are macerated and subjected to the action of bacteria, after which the undesirable portions of the fibers are readily removed.

Let us look for a moment at fermentation, that wonderful process which has been used for centuries, but which has only been understood for a quarter of a century. It is remarkable how widespread has been the use, from ancient times until the present, of fluids which have been subjected to fermentation. There are the wines of Southern Europe, the beer of the North, the ale of England, the distilled liquors of Scotland and Ireland, the rum of Jamaica and neighboring islands, the mescal from the cactus in Mexico, and the intoxicating drinks made from rice in Japan and China and from the milk of the cocoanut in the islands of the Pacific. One explanation doubtless is that the process is so very easy, and is universally instituted by natural conditions, provided only that the liquid to be fermented be procured. In the case of wine, it is only necessary to collect the juice of the grape and allow it to stand under certain easily obtained conditions, and the natural ferment deposited on the ripening grape during July and August will insure the transition of the grape-juice into wine. And after a certain time, if this fermented wine be permitted to stand, and be subjected to the action of certain other ferments which also are naturally deposited therein, this same wine will be transformed into vinegar. The processes involved in these industries have been developed to a high state of perfection without having received a correct explanation until but lately. Any consideration whatever of fermentation points us at once

to the labors of Louis Pasteur, that most eminent scientist, whose wonderful achievements have done so much to project the brilliant light of demonstrated fact into the dark recesses of the supposed mysteries of nature, so that they now stand revealed to us in a way that must excite our amazement because of their simplicity. If ever a man caused a revolution of ideas in scientific matters, it was he. What led him to these discoveries? Shall we attempt to glance at the first step in his wonderful work? Pasteur was educated as a chemist, and his ambitions were directed along the paths of this department of science. He was an enthusiast from the beginning, a diligent and painstaking worker, and soon the keenness of his trained intellect was manifested in the deductions which he drew from the experiments which he witnessed and performed, so that in early life he distinguished himself and attracted the attention of chemists everywhere by making a great discovery in molecular chemistry. While studying at the *Ecole Normale*, under Delafosse, Pasteur became greatly interested in molecular physics, when his attention was drawn to a note of the German chemist, Metscherlich, communicated to the Academy of Sciences, in which he said: "The paratartrate and the tartrate of soda and ammonia have the same chemical composition, the same crystalline form, the same angles, the same specific weight, the same double refraction, and, consequently, the same inclination of the optic axes. Dissolved in water, their refraction is the same. But while the dissolved tartrate causes the plane of polarized light to rotate, the paratartrate exerts no such action. M. Biot has found this to be the case with the whole series of these two kinds of salts. Here the nature and the number of atoms, their arrangement, and their distances apart are the same in the two bodies."

Pasteur at once questioned how it could be possible that the premises could be correct, and the conclusion not admissible that the two substances are absolutely identical.

He had begun the study of crystals and the determination of their angles and forms, and pursued his studies by repeating the measurements of angles and other experiments of de la Provostaye. While studying the symmetry of crystals, he found that the crystalline forms of tartaric acid and of its compounds all belong to the group of objects which have *not* a

plane of symmetry, and he imagined that the crystalline forms of paratartaric acid and of its compounds would have a plane of symmetry. He saw in this that it might be possible to explain the difficulty proposed in the problem of Metscherlich, and to establish the fact that the absolute identity of the two compounds did not exist. Experiments revealed that the tartrates of soda and ammonia, and others, also presented the dissymmetry manifested by the absence of any plane of symmetry; but, while not establishing in the crystals of the paratartrates an absence of all dissymmetry, he found that they all possessed it, but that certain crystals possessed it in one sense and other crystals in a sense opposite. Some of these crystals, when placed before a mirror, produced the image of the others, and one of the two kinds of crystals corresponded in form with the tartrate. From this he was led to conclude that he might be able to separate the crystals of the paratartrates, which are identical with those of the tartrate, and also those possessing a dissymmetry of an inverse kind, and exciting an action equally inverse on polarized light. This he verified on trial, and the discovery was communicated to the Academy of Sciences, where it occasioned considerable surprise. M. Biot, to whom the matter was referred for report, required Pasteur to repeat his experiments before him, and to separate those crystals which would turn the plane of polarization to the right from those which would rotate it to the left. This Pasteur was able to do with complete success. There was thus created a new chapter in crystallographic chemistry, and a new substance, the left-handed tartaric acid, was discovered.

It is impossible to give a brief, and at the same time an intelligible, *résumé* of his further researches along these lines. One conclusion which he reached, and in the study of which he was led to further attainments, was that mineral or artificial products, or the products of inorganic life, *have a superposable image*, and are therefore not dissymmetrical, while vegetable and animal products formed under the influence of life *have an image not superposable*; that is to say, they are atomically dissymmetrical, this dissymmetry manifesting itself externally in the power of turning the plane of polarization. This proposition was reached in endeavoring to determine the effect produced upon crystallization by varying the nature of his sol-

vents, either by an excess of acid or of base, and sometimes by adding foreign matters having no chemical action. He further thought, if he added to these compounds a substance possessing in itself the specific properties of dissymmetry, that this substance must give some of its own properties, and from the moment of its combination add something to the properties of the molecular group which acts like itself, and subtract something from the properties of the group which acts in the opposite manner. The effect, sometimes concordant, sometimes antagonistic, would cease to be alike in absolute quality. If this be the necessary condition of similitude as to molecular arrangement, this similitude would cease to exist, and there would appear all the differences of chemical and physical properties which constitute its outward manifestations. He shortly had a striking proof of the influence of dissymmetry effected by the phenomena of life. It had been observed by a German chemist that the impure tartrate of lime, if contaminated with organic matter, and in the presence of heat and moisture, would ferment, and yield various products. In examining this subject, Pasteur added some albuminoid matter to a solution of pure right-handed ammonium tartrate, and after placing it in a warm chamber he found that it fermented, in the course of which the previously limpid fluid became turbid in consequence of the growth of a small organism which acted as a ferment.

The same experiment was repeated with the paratartrate of ammonia, and the same micro-organism appeared and was deposited after fermentation. The two resulting liquids, however, were not identical, inasmuch as the solution of the paratartrate had obtained the power of deviation to the left in the polariscope, and finally, when the fermentation ceased, there no longer remained any right-handed acid in the liquid. He thus established the fact that molecular dissymmetry peculiar to organic matter intervened as a modifier of chemical affinity. Organized ferments, being almost always microscopic vegetables, containing cellulose and albumin identical with the same substances derived from the higher classes of vegetables, are equally dissymmetric. The nutrition of the ferment and the chemical changes are easier with one of the tartaric acids than with the other. The same facts developed in growing the common mould in a purely mineral soil

containing paratartaric acid as its only means of obtaining carbon. These studies opened up a wide field for research.

At this time Pasteur had become, at the age of thirty-two years, the Dean of the Faculté des Sciences at Lille. In this locality one of the chief industries is the manufacture of alcohol from beet-root and from corn. He therefore resolved to devote a portion of his lectures to the subject of fermentation, which, being profitable to his hearers, would attract attention to the new faculty, and at the same time he could continue his observations of the strange phenomena he had encountered in the fermentation of the tartaric acids. He felt that he had not observed isolated facts, but that these were phenomena connected with a great general law.

The easily induced phenomenon of fermentation was in a manner well-known, for it was seen that all organic matter after death was disintegrated by the processes of fermentation, of putrefaction, and slow combustion.

The theory which accounted for these changes was the ancient one that ferments are nitrogenous substances in a state of alteration which they undergo in contact with the air. The oxygen of the air was supposed to be the first cause of the molecular breaking up of the nitrogenous substances, and the molecular motion was thought to be successively communicated from one particle to another, and thus new products formed. This theory rested upon the experiments of Gay-Lussac, which had demonstrated that animal and vegetable matters could be preserved by enclosing them in sealed vessels and subsequently heating them. The phenomenon of fermentation was also explained by the supposed catalytic action of albuminoid substances—acting simply by their presence. The presence of micro-organisms in fermenting substances had been known since the days of Leeuwenhoek, but the relation which these cells bear to the chemical changes was not known. In the study of lactic acid fermentation, Pasteur was able to demonstrate this relationship, for he showed that the germs were the active agents. This he did by rejecting the complex fluids which had been used by other observers, and which, because of their complexity, were misleading; but he prepared some diluted yeast-water, to which he added some sugar and chalk, and filtered it. To this he added a minute portion of the gray-

ish matter which was deposited upon the sediment in the complex fermenting fluids used by other chemists, and in twenty-four hours a regular fermentation was established and an increasing quantity of minute cells deposited. But in order to entirely overthrow the current theories of fermentation, Pasteur made the crucial test of adding a very minute quantity of yeast-cells to a solution containing no decomposing nitrogenous matter, but containing only sugar, some salt of ammonia, and some phosphate of potash and magnesia. In this fluid the yeast multiplied and the sugar fermented. The same sort of experiment was performed with lactic acid ferment. Pasteur, now thoroughly interested in fermentation, soon discovered the butyric acid ferment, and showed its dissimilarity to the others. He demonstrated that the germs are very much alive, and that they not only exist without oxygen or air, but that they multiply best in the absence of air, and hence he called them anaërobics.

In acetic fermentation, Pasteur showed the relationship of the *mycoderma aceti*, which transforms the wine into vinegar. The process, so easily started by acidulating some good wine and permitting it to rest in a warm place, could be prevented by heating the sealed bottle of wine and preventing the access of air, which almost everywhere contains the spores of the *mycoderma*. He pointed out how vinegar could be more rapidly manufactured in vats than by the slow process of using the wine-casks to which some wine was added after taking out some vinegar. He explained the deterioration occurring in vinegar by fermentation continuing too long, so that ultimately there remained only some water containing carbonic acid, and called attention to the deterioration brought about by the contamination by the so-called vinegar eels. If the *mycoderma aceti* is not given the start in the process, the vinegar eels invade the surface, and the little plant has difficulty in growing; whereas, if the fermentation is properly advancing and the germs occupy the upper layers of the fluid, the vinegar eels are driven to the sides of the vessel, where they await the time when they can again move freely about, after the ferment has ceased its rapid growth. The process of making vinegar by permitting the dilute spirit to trickle through barrels containing beechwood shavings he also explained, and showed

that here, again, the fluid was simply exposed to a greater surface of air, but that the mycoderma aceti covered the wood with a tenacious film, and thus exerted its effect.

The question of spontaneous generation, which had vexed the minds both of scientists and of theologians, Pasteur disposed of by experiments, among which was the one wherein only superheated air was admitted to sterilized nutrient media contained in flasks, and air subsequently admitted only through a bent tube, which, while permitting the free access of air, prevented germs contained in the air from falling upon the contents of the flask. The maladies of wine formed another step in the study on micro-organic life, upon which we cannot at all enter. The few details which have been touched upon in the preceding paragraphs have been mentioned not only because of their historical interest, but also because we may rapidly learn the elements of bacteriology by understanding fermentation in its simpler manifestations.

When Pasteur had become famous by his achievements, which had materially advanced several important industries in France and elsewhere, he was solicited to devote some attention to a disease of silkworms, which in epidemic form had almost annihilated the silk industry, and thereby a portentous step was taken in elucidating the connection between bacteria and disease. A disease which, from the peppered appearance of the affected silkworm, was called pebrine, had for a number of years entailed a yearly loss of millions of francs, and had threatened the silk industry in France and in other parts of Europe. In 1865 Pasteur undertook the examination of this disease, and it is recorded that a few hours after his arrival at Alais, where the epidemic raged severely, Pasteur was able to demonstrate certain curious corpuscles contained in the sick worms. In reading the account, one is at once reminded of Cæsar's famous "*Veni, vidi, vici.*" It is not in accord with our present purpose to trace the several steps of this investigation, nor to recount the painstaking labor which it involved, and the indefatigable diligence with which he applied himself; how he pursued his studies while he and his family devoted themselves with ardor to the rearing of silkworms in order to facilitate his study, and to control his deductions as to the cause and methods of prevention, all of which he continued during five

years of partial residence at Alais; how he demonstrated the contagiousness of the malady by inoculating healthy worms and producing at will every manifestation of the disease; and, finally, how the French Emperor placed the imperial villa Vincentina, near Trieste, at the disposal of Pasteur, to continue and complete his studies, where soon, in consequence of the sale of healthy cocoons, a net profit of 26,000,000 francs was given to this villa. We are, however, greatly concerned with the ultimate results of these investigations, for they showed the pebrine to be a parasitic disease of the silkworm, which caused the worm to sicken and die with the manifestation of an eruption (?) on its surface; and he further pointed out that this disease is contagious; that it may also be transmitted by the worms scratching each other, and that it is hereditary, inasmuch as the eggs may contain the germs; and, finally, that the disease could be eradicated by examining the moths and permitting only the eggs to hatch which had been deposited by healthy moths. These conclusions were far-reaching in their results, for they pointed out the paths which, if pursued with due precautions, would lead to great achievements in the study of other diseases. This actually occurred with splenic fever, a disease which occasioned frightful loss, at times, in certain rural regions of France and other parts of Europe. Splenic fever and Pasteur! How the words kindle our admiration for the splendid work of this illustrious man! How I wish that there was time now to say what should be said on this subject; but there is not, and so the briefest reference only is possible.

Davaine and Rayer in 1850 had called attention to the bacteria in the blood of animals dead from splenic fever, but nothing came from the observation. Thirteen years later, because of suggestions received from Pasteur's work in other lines, the matter was again taken up. In 1877 Pasteur read a paper before the Academie of Sciences, wherein he showed that the bacteria above referred to constituted the sole cause of the malady. This he was able to do by carrying out the culture methods now so well-known in the bacteriological laboratory. Shortly thereafter he explained the contrary observations of others who inoculated from animals dead longer than twelve to twenty-four hours; that the germs of splenic fever, being aërobic, soon died in the blood of dead animals, being

deprived of oxygen, whereas then other septic anaërobic bacteria predominated. He touched upon immunity when he demonstrated experimentally why birds could not readily be inoculated with splenic fever, since their blood has a temperature of 41° or 42° Cent., and is so near the limit of 44° , where the germ perishes; but that if the bird be long chilled, and the temperature of its blood reduced, then it might be successfully inoculated; and, again, the fowl might be rescued by restoring or increasing the temperature of its blood. But there is really so much to be said about Pasteur's work relating to splenic fever, which must of necessity be left unsaid at the present, that I shall not even attempt another reference. Very interesting chapters have also been written about fowl cholera, septicæmia, and other diseases about which our knowledge was materially augmented by Pasteur's researches. We are all doubtless aware that many other names invite attention, were we at present concerned with questions of precedence, or even with a historical review of the development of bacteriology. However, the name of Richard Koch in Germany, in connection with his work in rinderpest and tuberculosis, demands at least this passing mention.

Micro-organisms have thus been shown to play an indispensable rôle in the transformations constantly going on in the great laboratory of Nature. It has been pointed out that in multitudinous ways they are the coadjutors and friends of man; and in a few notable instances they are his deadly foes. Various explanations have been offered as to the manner in which bacteria cause disease. Thus it has been said that they consume the food of the body; that they induce an oxidation of the tissues of the body, or reduce them; and that they produce a mechanical interference with the circulation of the blood; all of which are doubtless true. But the reactions excited in the tissues by the presence of bacteria must be taken into account. Syphilis, tuberculosis, actinomycosis, carcinoma, and others, appear to be examples of this, for they may be regarded as evidences on the part of the tissues to encyst or otherwise dispose of the foreign irritating elements. It is a fact, however, that all bacteria during their life-processes excrete certain matters which inhibit their growth, and are ultimately deadly to themselves; and, in addition, during the

growth of bacteria in any medium, there are produced a large number of by-products of decomposition which are highly poisonous. These two kinds of poisonous substances are doubtless the most potent causes of disease. These poisons are of such a virulent nature that, when injected into the body of an animal, they at once give rise to the symptoms of the characteristic disease and the effect is immediate; while, when the bacteria are inoculated, a certain period of incubation is required before the micro-organisms develop their characteristic symptoms. The sudden, serious illness induced by eating ice cream and other milk preparations is an example of such a poisonous substance, tyrotoxicon, produced by bacterial activity.

When the relationship of bacteria to disease was first demonstrated, it was supposed that each species of pathogenic bacteria produced a single definite disease, or that each disease had its definite bacterial cause; but this was found not to be invariably true. It is true of certain bacteria, as, for instance, typhoid fever, tuberculosis, tetanus, anthrax, gonorrhœa, cholera, and others; but other bacteria manifest their action in a manner not so definite, as, for instance, in inflammation of wounds, pus formation and septicæmia. In order to determine the definite relation of a particular pathogenic micro-organism to a definite disease, Koch has proposed that the following chain of evidence is essential: The bacteria must be found in the fluids or tissues of the sick or dead animal; they must be isolated and cultivated in suitable media through successive generations; a pure culture, introduced into an animal, must produce the disease; and in the sick animal the same bacteria must be found.

A number of bacteria have stood this test, and therefore we are justified in regarding them as the causes of the diseases which are ascribed to them.

In conclusion, I would say that, in thus briefly touching upon some of the elementary facts in bacteriology, I feel as though I had invited you to visit a great World's Exposition—even the great laboratory of Nature—where, in the few minutes at our disposal, it has only been possible to vaguely indicate some of the wonderfully interesting subjects which may engage our attention, but which we have not been able to rightly examine. If we would examine them, we must go ever so

slowly, and with reverential steps, for we are treading on almost sacred ground. That may surely be regarded as sacred which has been sanctified by such arduous toil, such painstaking application to multitudinous detail, such sacrifices of time and pleasure, and even of life, by some of the world's most gifted workers, as has been devoted to acquiring even the least of our known facts in bacteriology. Here flippant incredulity has no place.

SEQUENCES AND COMPLICATIONS OF URINARY DISEASES.

BY CLIFFORD MITCHELL, M.D., CHICAGO.

AMONG the more common sequences and complications of urinary diseases we find the following:

1. *A movable kidney* may cause kinking of the ureter, *hydro-nephrosis*, *pyonephrosis*, and *pyelonephritis*.

2. *Injury to the urethra* or even the passage of a sound may be followed by *acute hyperæmia* of the kidneys, suppression of urine, coma, and death in less than fifty hours.

3. Long-lasting *acute renal hyperæmia* is likely to result in *acute nephritis*.

4. *Polyuria* from any cause may result in *acute hyperæmia*.

5. Repeated attacks of *acute hyperæmia* may precede the onset of *renal tuberculosis*.

6. Long-continued *chronic renal hyperæmia* may finally result in a fatal *chronic nephritis*.

7. *Acute nephritis* may be followed by *chronic nephritis*, especially *chronic diffuse nephritis*.

8. *Chronic diffuse nephritis* may follow diseases of the lower urinary tract and malignant growths.

9. Cases of *chronic diffuse nephritis* (large white kidney), which do not recover after a year or two, may suffer from *renal atrophy* (atrophic stage of large white kidney).

10. An unrecognized case of *chronic diffuse nephritis* may suddenly exhibit the symptoms of an *acute hæmorrhagic nephritis*.

11. Long-lasting *stricture of the urethra* may be followed by *chronic fibrous* (interstitial) *nephritis* (contracting kidney).

12. *Displacements of the uterus*, resulting in pressure on the

ureter, may be followed by *hydronephrosis*, *pyonephrosis*, and *pyelonephritis*, or by *contracting kidney*.

13. *Contracting kidney* may be the result of *calculous pyelitis*.

14. *Contracting kidney* by distal constriction of the uriniferous tubules may cause proximal dilatation of them by the urine and formation of cysts (*multilocular cystic kidney*).

15. *Chronic diffuse nephritis* (either large or atrophied kidney) or *chronic fibrous nephritis* (contracting kidney) may either of them become complicated by *lardaceous degeneration*.

16. *Lardaceous degeneration* may follow *pyonephrosis* and *paranephric abscess*.

17. *Chronic diffuse nephritis* complicated by *lardaceous degeneration* may result in *suppurative nephritis* in one kidney.

18. *Lardaceous degeneration* may have *nephritic* complication.

19. Diseases of the lower urinary tract or surgical operations on the same may result in *abscess of the kidney* (*pyelonephritis*).

20. *Abscess of the kidney* may extend to the *paranephric fatty tissue*, causing *paranephric abscess*.

21. *Renal abscess* or *paranephric abscess* may communicate with the renal pelvis, causing *pyelitis*.

22. *Chronic renal tuberculosis* may cause *paranephric abscess*.

23. In women *pelvic cellulitis* may be followed by *paranephric abscess*.

24. *Paranephric abscess* may follow *surgical operations* on the testicle and spermatic cord after inflammation of the connective tissue about the bladder; or it may follow operations on the rectum, perinæum or uterus.

25. *Suppurative processes* in the gall-bladder, liver and spleen may be followed by *paranephric abscess*.

26. *Renal tuberculosis* is often preceded by tuberculosis of the testicle, epididymis or prostate.

27. Chronic inflammation of the lower urinary tract may be followed by *ascending tuberculosis*.

28. *Renal tuberculosis* in one kidney may descend through the ureter to the bladder and ascend to the other kidney.

29. Primary malignant disease of the testicles may cause secondary malignant disease in the kidneys (*cancer*).

30. Large retroperitoneal tumors may cause absorption of the kidney and replacement by fat.

31. *Diabetes mellitus* may cause *pyelitis* from irritation by saccharine urine.

32. *An abscess breaking into the renal pelvis may cause pyelitis by irritation; as may the presence of a foreign body in the pelvis of the kidney.*

33. *Failure to avoid sepsis after operations on the urinary tract may be followed by pyelitis; childbirth may be also a cause.*

34. *Acute nephritis may result in pyelitis due to bacterial irritant.*

35. *The colon bacillus may cause pyelitis, and this disease may follow even habitual constipation.*

36. *Pyelitis is sometimes a result of gonorrhœa, and of many infectious diseases.*

37. *Pyelitis is frequently followed by pyelonephritis.*

38. *Chronic pyelitis of long duration may be followed by lardaceous degeneration or chronic fibrous nephritis (contracting kidney).*

39. *Hydronephrosis may follow urethral stricture, enlarged prostate, renal calculus, or displacements of the kidney; spasmodic contraction of the ureter is a noteworthy cause.*

40. *An operation on the lower urinary tract in a patient with hydronephrosis may be followed by fatal pyelonephritis.*

41. *Chronic fibrous nephritis (contracting kidney) follows the dilatation of the pelvis in hydronephrosis, particularly in a double hydronephrosis with progressive enlargement.*

42. *Pyonephrosis may follow from the same causes as hydronephrosis, and especially from stone impacted in the pelvis of the kidney.*

43. *Malignant disease of organs near the kidney may be followed by pyonephrosis.*

44. *Renal calculus may result, if not removed, in serious renal inflammations and degenerations. The kidney may become a mere shell about the stone.*

45. *Impaction of the stone in the ureter may lead to ulceration, perforation, abscess, and death from peritonitis.*

46. *Ureteritis in women may be followed by spasm of the ureter (renal tenesmus).*

47. *Ureteritis may follow either pyelitis or diseases of the lower urinary tract.*

48. *Cystitis may result from gout (hyper-acid urine) or from diabetes mellitus (saccharine urine).*

49. *Slight cystitis may follow any infectious disease in which a slight degree of acute nephritis exists.*

50. *Cystitis* may commonly follow gonorrhœa (irritation from the gonococcus). It may be due to *extension of inflammation* in the urethra or prostate, especially when an unclean catheter is used; it will result from *retention of urine* from any cause, and from presence of *stone or foreign body*.

51. *Injury* is a common cause of *cystitis*; a common injury is pressure from the *foetal head*. Pressure from *feces* or *pessaries* may cause it, or from a *displaced uterus*.

52. *Cystitis* may result in *prevesical inflammation*.

53. In women *anal and rectal inflammations* are quite commonly followed by *cystitis*.

54. *Fissure in the neck of the bladder* in women is a common cause of symptoms erroneously referred to *cystitis* proper.

55. In pregnant women a *chronic congestion of the urethra* is not uncommon.

56. *Residual urine* is likely to be followed by formation of *stone in the bladder*.

57. *Stone in the bladder* may ultimately be followed by death from *pyelonephritis*, or by *abscess formation* in and about the bladder.

58. *Vesical tuberculosis* may result either from renal tuberculosis or by infection from the prostate and seminal vesicles. More commonly it results from *surface inoculation* by the stream of tuberculous urine from the kidney or renal pelvis.

59. *Tumors of the bladder* about the ureteral orifice may result in *hydro- and pyonephrosis*, *pyelonephritis*, or *contracting kidney*.

60. *Bladder tumors*, unless removed, inevitably result in death.

61. *Acute prostatitis* may result from irritation or sexual excess, but more commonly from gonorrhœa or stricture.

62. *Acute prostatitis* may be followed by *abscess*, or by *chronic prostatitis*.

63. In tubercular subjects a severe *chronic tubercular prostatitis* may be noticed.

64. *Enlargement of the prostate* results in distortion of the prostatic urethra, elevation of the level at the vesico-urethral orifice, and obstruction to the return of blood from the bladder.

65. *Enlargement of the prostate* may be, therefore, followed by *retention of urine*, *cystitis*, and *vesical stone*.

66. *Enlarged prostate* may result in a slight chronic *ureteritis* and *pyelitis*.

67. *Use of the catheter* may result in *urinary fever*, or in swelling of one or both testicles.

68. *Enlarged prostate* results sooner or later in dilatation of the bladder, hypertrophy of it, dilatation of the ureters and renal pelvis with stagnation of urine, congestion and *catarrhal inflammation of the entire urinary tract*, *pyelonephritis*, and death from *profound coma*.

69. Cases of *enlarged prostate* may be complicated by *chronic fibrous nephritis* (contracting kidney).

70. In *enlarged prostate* death from *uræmia* is sometimes noticed in patients who have not manifested marked evidences of renal disease. (See writer's paper "*Uræmia of Elderly Men*.")

71. Irregular or ungratified sexual desire may result in a *frequent desire to urinate* without presence of any inflammatory disease ("*Neuralgia*" of the bladder, *irritability of the bladder*).

72. *Diabetes mellitus* may cause diminution of sexual inclination, disorders of the cutaneous surface, asthma, gastric catarrh, constipation, cystitis, muscular pains, cataract, gangrene, retinitis, insanity, chronic nephritis, and coma. It may be cut short by death from *chronic pulmonary tuberculosis* or *acute pneumonia*.

73. *Diabetes insipidus* may lead to *exhaustion* from loss of rest, thirst and worry.

74. Various diseases of the urinary tract may be due to *irritation from use of drugs*, either internally or by injection:

Acute hyperæmia and acute nephritis to cantharides, turpentine, juniper, squills, nitre, copaiba, cubebs, mineral acids, oxalic acid, carbolic acid, certain salts of potash (chlorate, chromate, iodide), phosphorus, arsenic, corrosive sublimate, oil of mustard, salicylic acid, coal-tar compounds, boracic acid, opium, sharp condiments; to external applications of carbolic acid and iodoform; to frictions with tar, storax, Peru balsam, petroleum, naphthol, chrysarobin, pyrogallie acid; to various ointments used in scabies and psoriasis.

Acute nephritis may follow ptomain poisoning.

Chronic nephritis would appear to be a sequence of *alcoholism* in some cases.

Chronic nephritis (contracting kidney) is often a result of *plumbism* and of chronic poisoning by other metals.

Pyelitis may result from elimination of such poisons as copaliba, turpentine, cantharides or cubebs.

Cystitis may also be due to the same, or even to mustard or certain kinds of beer; strong injections may cause it.

Acute prostatitis may be caused by cantharides or other drugs, and by strong injections.

75. *Bacterial irritants, toxins, etc.*, are a fruitful cause of renal diseases, as follows:

Acute hyperæmia: It is possible that xanthin and paraxanthin may have something to do with death from suppression of urine in acute hyperæmia.

Acute nephritis is commonly due to the passage of soluble specific virus through the kidneys, *i.e.*, to products eliminated by pathogenic microbes; and also to sepsis.

Chronic nephritis (contracting kidney) is often referable to syphilis, malaria, or gout.

Lardaceous disease is recognized as the result of the long-continued action of toxins produced by the staphylococcus pyogenes aureus.

Puerperal nephritis is thought to be a toxæmia in many cases.

Renal abscess is due either to the entrance of pyogenic bacteria from the circulation or to extension of inflammation from below.

Paranephric abscess and *genito-urinary tuberculosis* may be included in the same general category as the above.

Pyelitis may be due to the action of the colon bacillus or to the bacterial irritants of various infectious diseases.

Pyonephrosis may sometimes be septic or due to bacterial irritants.

Cystitis may be due to the local action of the bacteria or toxins of its primary disorder.

Acute prostatitis is often due to the action of the gonococcus.

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ACUTE DIFFUSE GONOCOCCUS PERITONITIS.

BY ALFRED WANSTALL, M.D., BALTIMORE, MD.

(Read before the Maryland State Homœopathic Medical Society, October, 1900.)

HARVEY W. CUSHING, M.D., published, under the preceding title, in the *Bulletin* of the Johns Hopkins Hospital for May, 1899, an article of great interest to the general practitioner. It consisted of a historical review of the literature on the subject and the report of two clinical cases of his own. It is my purpose here to abstract the historical part of the article as briefly as is consistent with its understanding, and to give a condensed history of his two clinical cases, to which I shall then add the brief histories of two cases passing under my own observation, which I believe properly come under the heading of this article.

Cushing opens his paper as follows: "Owing to the influence of Bumm's original assertion that gonorrhœal processes remain limited to surfaces lined by mucous membranes, it had until comparatively recent times been generally doubted that the gonococcus of Neisser, without the association of the more common pyogenic organisms, was capable of inducing an acute general peritonitis. It is, however, now recognized that structures other than those of an epithelial character are liable to invasion by the gonococcus; and, indeed, parts covered by endothelium seem particularly liable to attack by this organism.

Thus the joints, pleura, peri- and endocardium are liable to gonococcal infection; and although these affections are metastatic in character, and occur during the course of a general gonococcus septicæmia, they nevertheless suffice to prove the untenableness of Bumm's original statement. Nevertheless surgeons have clung to the belief of the immunity of the peritoneum to gonococcal infection, and it has generally been granted that gonococcal processes in women are checked in the neighborhood of the abdominal ostia of the tubes, where, by continuity of extension, a peritonitis otherwise might be readily induced. We must, for the present, continue to believe that such an inhibition of the growth of the organisms does usually occur when the serosa is reached, but whether, under unusual circumstances, a general peritonitis may not follow by implantation of gonococci from the tubes upon the peritoneum, has hitherto been regarded as extremely improbable."

He goes on to say, "The usual conception is concisely expressed by Frederick Treves as follows: 'Peritonitis has been met with in association with gonorrhœa, but inasmuch as the gonococcus cannot survive in the peritoneal cavity, it is doubtful whether peritonitis due to the gonococcus alone has any existence. . . . It is very probable that a mixed infection is the cause of the pyosalpinx often met with in gonorrhœa. That pyosalpinx may lead to acute peritonitis is undoubted, but it has not been demonstrated that such a complication is due to the action of the gonococcus alone; it is probably the outcome of a mixed infection. . . .'

"Bumm, in 1899, published the following statement: 'Whether there is a gonorrhœal inflammation of the peritoneum is to me very doubtful. The microbes of gonorrhœa appear to exercise pathogenic effects only on mucous membranes, and perish in serous cavities. Pure gonorrhœal pus, from pus-tubes rupturing into the peritoneal cavity, acts only as an aseptic foreign body. It is encapsulated, etc.' He goes on to say that only a mixed gonococcal infection can be followed by a septic peritonitis."

Subsequently Bumm further emphasized his views as follows: "He believed that gonorrhœal infections ran a course as a superficial mucous membrane affection merely, and never penetrated the deeper connective tissue, in which the gonococcus

would perish; that the organism of Neisser had nothing to do with septic processes, which occurred only through the medium of mixed infections; that the gonorrhœal process, usually localized in the urethra and cervix, under certain influences, primarily that of menstruation, but also during the puerperium, and from coition and instrumentation, might extend to the endometrium of the body and tubes. Beyond these parts, however, he believed the process did not pass, being limited by the endothelial peritoneal surface."

Wertheim, whose views are directly opposed to those of Bumm, demonstrated conclusively that "a circumscribed pure gonococcal peritonitis could be produced experimentally in animals, and was possible in human beings." Subsequently he reported a case of acute pelvic peritonitis found, during a laparotomy for salpingitis, in the exudation of which he demonstrated gonococci and cultivated them on blood-serum agar. He believes this to be the first assured case of acute gonorrhœal infection of the peritoneum in the human being.

"The principle which Bumm has laid down, namely, that peritoneal infection after gonorrhœa was more apt to occur after menstruation, parturition, etc., soon became emphasized by the reports of cases in the literature tending to disprove the common belief that the infection to involve the general cavity must be a mixed one. The observations alluded to did this, more because of negative findings of the pyogenic group than by any positive demonstration of the existence of the gonococcus alone."

Veit reported five cases of acute diffuse peritonitis occurring in women in child-bed; two became infected before the confinement, and three during the puerperium. After a stormy period of a few days, the threatening symptoms disappeared, leaving a condition of chronic gonorrhœal pyosalpinx. He declared the peculiar anatomical condition present in the puerperal state occasioned the rapid onset of the peritonitis, and suggests that the lochia affords a good culture-medium for the gonococci. In this Bröse agrees, because gonococci appear in great abundance in old, infected cases, during the child-bed period.

"Bröse reported two cases of non-puerperal peritonitis, for which he held the gonococcus alone responsible. The cause of the peritonitis on one occasion was the rupture, during

manipulation, of a small gonorrhœal pyosalpinx. Signs of collapse and general peritonitis followed. In the light of Wertheim's and Veit's observations, Bröse . . . withheld operation, and after four days the symptoms subsided. His second case was one of spontaneous rupture of a gonorrhœal tube. Here, also, extreme symptoms, not only of pelvic but of generalized inflammation with profuse vomiting, extreme meteorism, and collapse so marked that the case looked hopeless, followed. Again operation was withheld, and by the sixth day all symptoms had subsided. Bröse naturally believed that these peritonitides, differing so greatly in their course and prognosis from the ordinary streptococcus and staphylococcus invasions, represent a distinct form of peritoneal infection. Their symptoms, such as great pain, general tenderness, vomiting, meteorism, singultus, high temperature, small and frequent pulse, are the same as those from general peritonitis from any cause. Their prognosis is, however, widely different, as complete recovery, except for the chronic condition left in and about the appendages, is the usual outcome. He acknowledges, however, that as no case has been confirmed by section, the pathological anatomy and the bacteriology of 'gonorrhœal peritonitis' are only matters of conjecture."

The evidence necessary to set aside this as a matter of conjecture Cushing believes he has furnished in the report of these two cases. They are characterized by the fact that their nature was unsuspected and the diagnosis not made until the gonococci were demonstrated in the abdomen during the operation. Cushing believes that they are sufficiently conclusive to establish beyond question the existence of a diffuse, pure gonococcus peritonitis.

The first case was a maid of 25. History and examination negative on admission. Five days previously menses began, and two days later partially ceased, and abdominal pains set in the same day. On admission, temperature, 100.5°; pulse, 100; leucocytes, 19,000. Moderate evidence of a peritonitis. Symptoms more marked the following day. General abdominal tenderness more marked; temperature, 102.8°; leucocytes, 22,000. Median exploratory laparotomy. General peritonitis. Acute double salpingitis. While the examination was progressing, the cover-slip examination—from the surface

of the appendix—was reported as showing a deeply staining biscuit-shaped coccus, for the most part intracellular, occurring in pairs, and not decolorizing by Gramm's method. This led to a further examination of the Fallopian tubes. Like the rest of the exposed viscera, they were deeply congested and quite abundantly covered with lymph; they were somewhat swollen, but not markedly so. There were no adhesions of any note about them, and the fimbriæ were free. Both appendages presented the same appearance. On gently squeezing the tube, and stripping it toward the free end, a thick drop of purulent material could be made to appear. . . . An abundance of organisms with the morphology of gonococci were demonstrated in the pus.

No organisms could be positively identified as gonococci in the vaginal secretions.

After the operation it was learned that the patient had been exposed to gonorrhœa, off and on, for five years.

Bacterial examination: Cultures from the abdomen negative. Pus from tubes showed gonococci and no other bacteria. Cultures from tubes not made. Cushing says, in a note: "While the positive cultural evidence of the presence of the gonococcus in this case would have been desirable, the certain identification of the organism in the tube and the absence of growth on ordinary media make the diagnosis of gonococcus peritonitis convincing."

Cushing further says, had the cover-slip examination not been made, possibly the source of infection might not have been recognized, and not improbably the peritonitis would have been regarded as a chemical one.

The second case was a girl of 18, admitted complaining of pain in right side of abdomen, with persistent nausea and vomiting. Six days previously she awakened with abdominal pains, up to which time she was well. Constipation, nausea and vomiting. Some hiccough. Her general appearance was that of collapse, with peritonitis. A provisional diagnosis was made of general peritonitis, presumably of appendicular origin. Flushed cheeks, coated tongue, general appearance of acute toxæmia. Respirations costal in type, 34 to the minute; pulse small, 100, regular, and of fairly good character; temperature, 98.8°. Extremities cold, not clammy. Leucocytes, 26,000.

Abdomen: no distention, marked tenderness on the right side, protective spasm not marked. Exploratory laparotomy. General peritonitis. Gonococci demonstrated in exudate. Double salpingectomy.

The whole serosa was found deeply injected and uniformly covered with a layer of fibrin. No free fluid, no pus. There was nothing to draw attention to any particular organ in searching for the origin of the peritonitis. The tubes were examined early in the search; they were, like the appendix, congested and covered with lymph; but the fimbriæ were free, and there was no evidence that the pelvic peritonitis antedated that in the upper portion of the abdomen. After a fruitless search the tubes were re-examined, when, with some difficulty, it was found that a purulent drop could be brought to the abdominal ostium, in which biscuit-shaped diplococci, not decolorizing by Gram's method, were demonstrated in moderate numbers.

An unsuccessful attempt was made, subsequent to the operation, to demonstrate gonococci in the vaginal discharge. She afterward admitted that she had been frequently exposed to infection for a year, and had leucorrhœa and painful micturition for six months. She had been re-exposed before her last menstrual period, and had a return of abundant discharge.

Bacterial report: Cover-slip preparations from the purulent contents of the tubes showed a considerable number of diplococci, with the typical morphology of the gonococcus. Smears from the peritoneal cavity show a few gonococci. Bullion culture from the pus from the peritoneal cavity shows no growth. Bullion culture from a mass of fibrin from under surface of liver shows fairly large diplococci, typical morphologically of the gonococcus. A hydrocele fluid-agar tube, inoculated with a mass of fibrin from Douglas's pouch, shows diplococci, morphologically the same as gonococci, in pairs and tetrads.

Cushing sums up his article with the following conclusions:

1. "The gonococcus is capable of causing a specific infectious disease, namely, gonorrhœa, and, at the same time, other and less specific pathological conditions.

2. "There is experimental proof that in certain small animals the gonococcus can set up acute alterations in the peritoneum homologous with the acute septic serositis in man, but differing from these in their tendency to rapid and spontaneous healing.

3. "Hitherto there has been wanting conclusive proof that in the peritonitides attendant upon gonorrhœa occurring in women, the gonococcus was solely or chiefly concerned. The inflammations had been variously regarded as mixed infections and chemical inflammations.

4. "The cases reported in this paper bring for the first time convincing evidence of a diffuse, general inflammation of the abdominal cavity, caused by the gonococcus.

5. "It has been recognized that the extension of the gonorrhœal infection from the genital organs to the peritoneum may occur in the puerperal state; a similar sequel is shown to be possible during menstruation.

6. "Such ascending forms of gonorrhœa doubtless, under ordinary circumstances, remain localized in the pelvis, and rarely demand surgical intervention in the acute stage.

7. "A general involvement of the peritoneum such as occurred in the two cases given must either be rare or unrecognized, and may depend upon some especially receptive condition of the serosa or of the virulence of the organism.

8. "The peritoneum is not more immune than are the pericardium or endocardium to gonococcal infection, and, being more exposed, suffers more commonly in females, although the relatively benign course of the disease makes it a rare condition to come to the attention of the surgeon in the acute stages."

My first case was as follows:

Mrs. ——— called at my office on January 26, 1899, complaining of a very profuse leucorrhœa, with which she had been suffering for a short time. As she was unwell at the time, an examination was not made, nor was she suspected of having anything more serious than an ordinary leucorrhœa. Three days later, January 28th, she was seen at her home, confined to bed, with every evidence of the beginning of an attack of grippé; malaise, headache, general aching and slightly feverish. As she lived in the country, she was not seen again until the 30th, Sunday intervening. During the night of the 29th, Sunday, she had a chill, followed by high fever and severe abdominal pain. On the morning of the 30th she was found with a temperature of 102.4°, pulse 140, small, but otherwise of good character, and with a drawn and anxious countenance. The abdomen was moderately distended, tympanitic, and very

sensitive to the touch. She complained of severe and spontaneous pain over the surface of the liver; it was increased by motion, by touch and by breathing to such an extent as to call for strapping. There were no specific points of tenderness except that already mentioned over the liver, and the lower abdomen was explored carefully, with negative results. The patient presented a typical picture of a peritonitis of a moderate grade, and my opinion of it at the time was that it represented a manifestation of the grippe.

On the following day she was generally better; temperature, 100° ; pulse, 110. Abdomen still distended, tympanitic and sensitive, with spontaneous pain as above noted. The patient's condition remained practically unchanged during the following week; temperature fluctuating between 99° and 100° , pulse between 100 and 112. On the 8th of February temperature suddenly went to 102° and the pulse to 120; severe pain set in in the bowels, with frequent loose movements, free blood and bloody mucus. The trouble with the bowels subsided in a few days, the temperature on the 9th having dropped to 99.3° and the pulse to 112. The disturbance of the bowels relieved my mind in regard to the abdominal trouble rather than otherwise, as it tended to confirm my belief that I had to do with a manifestation of grippe, and not with a more serious trouble.

For several days following the improvement in the bowel trouble the temperature fluctuated between 99° and 101° , and the pulse between 100 and 116, the abdomen still somewhat tympanitic and tender, when she began to complain of pain in the lower abdomen, the pain in the hepatic region increased, and the right arm became useless from intense pain, spontaneous and paroxysmal in character, in the shoulder-joint. There was no swelling, heat or redness of the shoulder, but it was absolutely intolerant of the slightest touch or motion. It was the advent of the trouble in the shoulder that occasioned my mind to revert to the leucorrhœa for which she had first applied for treatment, and which had continued profusely during the present attack, and excited the suspicion that it was a gonorrhœal discharge.

An examination made at this time, February 21st, showed both tubes easily palpable, and painful to touch. The profuse cervical secretion obtained at this time showed, on examination,

gonococci in abundance, and mostly intracellular. The pain and lameness of the shoulder subsided gradually, as did the abdominal symptoms. The next menstruation appeared on the 5th of March, just five weeks after the cessation of the preceding one. Her convalescence was extremely slow, and extended well into the early summer, although her health to-day is as good as usual, which was never robust. She has had no menstrual disturbances since, nor any subjective evidence of pelvic disease.

Gonorrhœa was denied at the time on the part of the husband of this lady, although I learned subsequently, from an anxious relative of the patient, that he had been using a syringe for a reputed kidney trouble.

Note: An early knowledge of the fact that this patient had gonorrhœa would have saved me many anxious moments, and would have enabled me to give an early favorable prognosis, as far as the immediate symptoms were concerned, and to have forecast the tardy and probably incomplete recovery.

CASE II.—My second case was as follows: I was attending Mr. —, who was confined to bed with cystitis complicating a frank case of gonorrhœa in the stage of full development. His anxiety as to its possible effect upon his wife's approaching confinement (she was then supposed to be in her eighth month of pregnancy) led him to call my attention to the fact that she was in all probability infected.

On inquiry I learned that she had been suffering for several weeks with a very profuse acrid leucorrhœa, and dysuria. She was not examined, for obvious reasons; she was prescribed for, and vaginal douches of bichloride 1: 10,000 were ordered. In the course of two or three days she called my attention to the fact that she was having a bloody show, that she was suffering with pains in her back, and that, in her opinion, labor was imminent.

As her time was not yet up, she was ordered to bed and the douches were discontinued, and, in case she went into labor, instructions were left for the nurse to douche the vagina thoroughly with the bichloride solution, and to make the patient surgically clean.

She went into labor on the morning of August 16th, within twenty-four or thirty-six hours from the beginning of the threat-

ening symptoms. Contrary to my expectations, and to my great regret, the nurse, on her arrival, made a vaginal examination.

Labor was normal and not prolonged. No vaginal examinations were made during its progress, save the one by the nurse referred to above. The placenta was expelled by external compression, everything coming away perfectly. Absolute cleanliness was ordered. No vaginal douches were allowed, but the vulva was spread apart with the fingers and thoroughly flushed with a bichloride solution three times a day.

Up to the 20th, the fourth day, except the ordinary lochia and evidences of a profuse purulent discharge, with a morning temperature of 99° and an evening temperature of 100° , there had been no other unfavorable symptoms. On the afternoon of this day she had a chill, followed by vomiting, singultus, and severe abdominal pain set in. When I saw her later in the day the abdomen was distended, tympanitic, and very sensitive to the touch. There was no special point of tenderness except the ordinary soreness over the uterus. Her countenance was anxious and drawn; temperature, 103.8° , and pulse 130, but of good character. She presented the picture of an acute peritonitis. As soon as preparations could be made, the vagina was first thoroughly washed out, and several quarts of a hot bichloride solution 1:10,000 were run through the uterus.

On the 21st the temperature had fallen to 100° in the morning and 100.4° in the evening. The condition of the abdomen was unchanged. There was practically no vaginal discharge, but frequent vaginal douches were ordered.

Her condition remained practically unchanged until the 28th; temperature hovering between 100° and 101° ; abdomen sensitive and tympanitic, and urine very scanty; anorexia and occasional singultus. On this day she vomited; temperature went up to 102.8° , pulse to 124. The right arm became entirely useless from pain in the shoulder-joint. There was neither heat, redness nor swelling of the shoulder, but it was exquisitely sensitive to either touch or motion, and the seat of frequent paroxysms of spontaneous pain, so violent that the patient's cries could be heard by the neighbors. The temperature and pulse began to fall almost immediately to what it had

been before the shoulder trouble appeared, but the pain and inability to use the shoulder lasted the greater part of the week in varying intensity, and then began to subside. The abdomen still remained tender and appreciably distended. When I went away for my vacation, on the 15th of September, the patient was still confined to bed, and not entirely free from fever. Her convalescence was very slow, but, at her best, she was a woman of frail physique. Local examinations made after her recovery failed to show any tubal or pelvic trouble, and at the present time she is in her usual health, and menstruates normally.

Remarks.—It will have been noticed that the first case occurred during menstruation and the second during the puerperal period; the rapid subsidence of the fever after a rather stormy onset, and the general good character of the pulse, are noticeable features in both cases. It is a somewhat remarkable coincidence that both cases should have had trouble in the right shoulder, the characteristics of which were identical in both cases, except that it made its appearance much later in the first case. In this connection it will not be amiss to say a few words about the child: After its birth, and before ligating the cord, a very careful toilet was made of the face, eyelids, lashes, etc., and, as soon as the cord was ligated, Crede's prophylactic instillation of nitrate of silver was done in each eye. Notwithstanding this precaution, on the fifth or sixth day purulent ophthalmia developed in one eye. It ran the usual course. About the first of September, and after the eye had been well for several days, my attention was drawn to the fact that the baby did not use its right arm, and that it was evidently suffering pain. An examination showed the arm hanging at the side, nor was there any evidence that the child had the least control of it, as the examination, while exciting pain, occasioned not the least resistance. The shoulder was swollen, red, hard, hot and very painful to touch and motion. The mother herself, as well as her attendants, were absolutely certain that the child had not sustained an injury of any kind, nor had a fall. The arm was strapped to the body, and the shoulder first treated with antiphlogistin; with the subsidence of the heat and redness, clay poultices were substituted for the former dressing. The swelling or induration yielded more slowly, and after the first of October, on my return home, the child was only regaining the use

of its arm. This is the second instance coming under my observation of a secondary infection following a purulent ophthalmia in new-born children.

Cushing makes the statement in his summary that cases of gonococcus peritonitis "must either be rare or unrecognized." I am inclined to believe that they are unrecognized, and probably owing to their general tendency to be mild in character. Cushing's two cases, owing to the moderate pulse and temperatures, do not create the impression that, in private practice and under conservative treatment, they would have been operated, or at least when they were; but it must be borne in mind that the etiology of neither case was known before the operation, and as an offset to the moderate pulse and temperatures, a high grade of hyper-leucocytosis existed in both. In striking contrast to these are the two cases of Bröse, already quoted from Cushing's historical review. One was a case of rupture of a gonorrhœal tube during an examination, and the other the spontaneous rupture of a gonorrhœal tube; in both cases, in spite of most alarming symptoms, and wholly on the ground of their gonorrhœal origin, he withheld operation, and both cases recovered spontaneously.

The lesson we can learn from these cases is, first, in cases of peritonitis occurring suddenly during menstruation or the puerperal period, if other causes are wanting, not to overlook gonorrhœa as a possible cause; and, second, if its existence can be established, then we are justified in pursuing a more conservative course than we would were this not the case.

The following case came under observation since this paper was written; and, while it cannot be classed as a case of acute diffuse gonococcus peritonitis, it presents so many features of interest in connection with this subject in general, as to lead me to report it here in detail.

Mrs. —, formerly a widow, contracted her second marriage in June of this year, and went to live elsewhere. She returned to consult me on the 14th of August, complaining of frequent and painful urination and bleeding from the urethra, with which she had been suffering for three weeks, and during which time she had been under treatment without relief. It was worse during the day, and especially worse when moving about, with almost complete remission of the painful

symptoms during the night, although she was frequently disturbed to urinate. Suspecting the presence of an urethral caruncle, an examination was requested.

The urinary meatus was found almost surrounded by granulating tissue on an entirely flat base, and a speculum examination showed that it extended practically the whole length of the urethra; it was very irritable, and bled freely from the contact of speculum and probe. There was no appearance of a purulent discharge from the vagina or the urethra, except, perhaps, an undue moist appearance of the vaginal entrance, nor had the patient suffered from leucorrhœa before or after the present marriage. The ready and profuse bleeding from the urethra made it impracticable to obtain a cover-slip smear from it, and only after some difficulty a smear was obtained from the vaginal secretions by direct contact of the cover-slip. Its examination showed abundant streptococci, and here and there free diplococci. After diligent search, only one pus-corpuscle was found containing two pair of diplococci. The result of the examination, while very suspicious, was, in my judgment, insufficient to justify a positive diagnosis of gonorrhœa.

On the 20th of August the lady's husband came to the city to inquire about her condition. In answer to my questions he related the following interesting history: He had had gonorrhœa in 1897, *i.e.*, three years ago, and off and on since had an undue moisture about the meatus. Four months before his marriage, and before fixing his wedding day, he consulted an eminent specialist in a neighboring city as to the character of the discharge and the advisability of his contracting marriage. Cover-slips were made from it, and he was informed by letter that the discharge was benign, and that it was safe for him to marry. Immediately before his marriage he had the examination repeated by the same physician, and received a second negative (and favorable) report by mail.

After marriage he noticed the discharge increased somewhat; it was never profuse enough to flow, but at times caused a noticeable stain on his underwear. This fact and his wife's trouble renewed his anxiety; and forty-eight hours before his visit to me he had consulted a competent physician in this city, who made and examined cover-slip preparations, passed sounds, etc., and who informed him that the discharge was not gonorrhœal, and could not have occasioned an infection.

At my request he permitted me to make an examination. He had urinated shortly before. The meatus was not injected. Spread apart, the urethra was obviously too moist, but no secretion could be caught in the platinum loop. A cover-slip smear was only had by pressing the glass against the urethral orifice. Fixed, stained and examined, it showed gonococci in moderate but very positive number, both free and within pus-cells. Considering the character of the smear they may be said to have been abundant—altogether as pretty a cover-slip of the kind as I have seen.

Now as to his wife's subsequent symptoms. The urethral trouble was practically well, the tissues more normal in appearance; bleeding and frequent and painful urination stopped before her menses came on, on the 30th day of August. On the 31st, the second day of the menstrual flow, she was attacked with pain at the pit of the stomach; the pain was severe, and radiated over both hypochondriac regions. The pain was continuous, but with paroxysms of aggravation, and the regions mentioned sensitive and sore to the touch. The pulse was normal, the temperature not taken. No gastric nor intestinal disturbance, and no other significant symptoms except that she was compelled to lie down all the time, and on her back, with both thighs flexed on the abdomen. The pain persisted through this and the following day in greater and less intensity, passing off gradually during the night. On the 3d of September she was practically well, her menses also ceasing on this day.

On September 4th, at 5 o'clock A.M., the pain again set in in the epigastric region, and radiating over both hypochondriac regions as before, but now extending to the back and over the abdomen generally. Abdomen, in general, sore to the touch, but no distention nor protective spasm. Patient lies on her back, with both thighs flexed on the abdomen. Later in the day the pain increased in intensity, and the patient vomited. Pulse normal, temperature normal. No other bodily disturbance, the vomiting undoubtedly from the pain; otherwise, stomach and bowels normal. The patient lying in absolute quiet on her side, with the thighs flexed on the abdomen, and her arms folded around her legs. It is apparent that she is in great pain. The pain had not abated in severity in the

early evening, but at 10 o'clock she thought it was decreasing; by midnight she slept; and on the following day, September 5th, she was entirely relieved, and two days later felt well enough to accompany her husband home.

She has returned to me at intervals since; has had two or three additional less severe attacks of pain, and a rather profuse leucorrhœa, in which it has not been possible to positively identify gonococci. There is no palpable evidence of tubal disease, and while her urethral mucous membrane is still somewhat granular, she is free from bleeding, and urination is normal in frequency and without pain.

Remarks.—This case is by no means convincing, yet the feeling is strong in my mind that the attacks of pain were associated with the gonorrhœal infection, as they were unique in her experience, and nothing else existed to account for them even as a probability.

The unreliability of an opinion based on the absence of gonococci from the urethral discharge of a male, and the danger of advising marriage even under these conditions, is well illustrated in the case of the husband of this lady; and the possibility of a gonorrhœa running its course in a female, from the beginning, as a chronic disease, *i.e.*, without acute leucorrhœal symptoms sufficient to attract her attention, is illustrated in her own case. It must be borne in mind that her infection originated from gonococci of probably low vitality; and as this was the lady's second marriage, the possibility that she, too, might have had a latent gonorrhœa, dating from her first marriage, cannot be excluded.

CALCAREA CARB. AND SILICEA IN CATARACT.—A woman, aged sixty years, had a hard cataract of the usual greyish color, with a yellowish tint, which obscured her vision. The lens-fibre, however, had not become degenerated to any extent. Calcarea carb., 2x trituration, two grains every morning; silica. 3x trituration, two grains every evening, were advised. The lady was also advised to bathe the eyes, three times daily, with a lotion, composed of thirty minims of euphrasia tincture in half a glass of water. Within one month, improvement was noticed. Within five months, the cataract had entirely disappeared. Dr. Kopp, who narrates this interesting case, is conservative; he does not feel sure that this treatment would prove as effective in a case farther advanced, but should expect the same brilliant results in cases similar to the above.—*Homœopathic World*, March.

A MODIFICATION OF THE PICRIC-ACID TEST FOR ALBUMIN.

BY CHARLES PLATT, M.D., PH.D.

(Chemical Laboratory, Hahnemann College, Philadelphia.)

I FEEL that an apology should accompany the proposal of a new test for albumin, and yet a test with the double advantage of simplicity and accuracy may be accepted. Picric acid having been preferred by many to the more corrosive nitric acid in office work, and this, too, despite the fact that the picric-acid test is subject to error, it may be of interest to indicate a method which will facilitate the preferred test, and at the same time render it somewhat more accurate.

The modification proposed is slight but efficient, namely, the addition, to a saturated aqueous solution of picric acid, of cane sugar, in the proportion of fourteen grammes of the latter to one hundred cubic centimeters of the former. The advantage obtained lies principally in the fact that the increased density of the solution renders possible the making of a clearly defined contact-test, floating the urine over the acid, and that, thereby, even small traces of albumin may be easily discovered. A saturated solution of picric acid in water has a specific gravity of about 1.007; the proposed solution, a specific gravity of about 1.065.

The test is made as follows: An eight-inch glass tube of approximately one-fourth inch internal diameter is painted black on one side for a distance of two inches from one of the ends. This tube, dipped into the urine, is closed above with the finger, withdrawn, touched to a bit of filter paper to remove excess of urine, and then dipped into the picric-acid solution, and the latter allowed to rise in the tube beneath the urine. The faintest possible trace of albumin is plainly visible at the contact as viewed against the dark background of the painted strip. In dipping the tube with the urine into the picric acid, insert it first to such a depth that the surfaces of the acid and of the urine will be at the same level; then remove the finger, and gently lower the tube. With this precaution the acid rises quietly, and does not become unduly mixed with the sample. To prevent precipitation of peptones, alkaloids, etc., the picric-acid solution may be *gently* warmed before using, but on no account should it be suddenly heated.

TINCTURES OR FLUIDS—WHICH ?

BY EDWARD A. BENDER, PH.G., PHILADELPHIA.

TRADITION is strong with all of us. The pharmacy of a hundred years ago was crude, and the tincture was its best product. The brilliant results achieved by the new therapeutic system which arose in those days has aroused in many modern physicians an almost superstitious belief in the superior efficacy of the old pharmaceutic products with which such successes were achieved. But is this belief justified by the facts? There is no magic in drugs or drug preparations. The day of the alchemist is past, and we know that the activity of any medicine is dependent upon the presence within it of certain definite chemical substances. Indeed, from many drugs these active principles can be extracted and used in a pure state; and at present the tendency on the part of leading therapeutists is toward the use of alkaloids, active principles, rather than continued use of the inexact, often faulty, solutions of the drug. This would become much more generally the case, especially on the part of those who prefer to use large doses, were it not that certain drugs—for example, *digitalis*—contain a number of active principles, and this ready-made combination cannot be duplicated by the chemist. It is absurd, however, to fix a rule, and then declare that in this manner alone can a proper solution of the active principles of drugs be obtained. Dr. F. Mortimer Lawrence tells me that a tincture of *digitalis* prepared according to the method of the homœopathic pharmacopœia is utterly unreliable when given for its physiological effect. In the case of *gelsemium*, originally introduced into medicine by the eclectics, even the old-school pharmacists long believed, so strong is the force of tradition, that only a green-drug preparation afforded the effects peculiar to the drug. Finally, however, Messrs. Parke, Davis & Co., themselves manufacturers of a green-drug tincture, made a careful investigation into the matter, and as a result it was proven that a preparation made from the dried drug was not only quite as active, but was more uniform in its strength and results. That ended the vogue of the green-drug tincture.

In the March number of the *HAHNEMANNIAN MONTHLY* Dr. T. H. Carmichael takes up the cudgels in behalf of the new pharmacopœia, of which he is an associate editor. His article is an interesting statement of the method by which it is endeavored to secure tinctures which uniformly represent one-tenth of the power of the crude drug. In his enthusiasm for these preparations Dr. Carmichael rather goes out of his way to condemn the new class of liquid preparations called fluids, which, he admits, have found favor with some practitioners. These fluids are solutions of dried plants (carefully selected) in 95 per cent. alcohol, in the proportion of one part of the plant to two parts of alcohol, *i.e.*, five times the strength of the tincture. Dr. Carmichael claims that to use strong alcohol as a universal solvent would be to leave undissolved the principles of many plants, and that "the proportion of solvent (two parts to one part of plant) is entirely too small to exhaust the drugs, in spite of the fact that repercolation is used. In support of his contention he instances bryonia, a plant notoriously soluble in water, but he ignores the fact that bryonin itself is extremely soluble in alcohol. Had he gone a step farther, and investigated the solubility of the principles of some of his other drugs, he would have found, for example, that one part of each of the following is soluble in the indicated proportions of water and alcohol respectively:

	Water.	Alcohol.
Belladonna,	130	3
Aconite,	150	5
Cinchona,	1670	6
Cocoa,	700	very soluble.
Digitalis,	1000	soluble.
Hydrastis,	nearly insoluble.	very soluble.
Hyoseyamus,	500	very soluble.
Nux vomica,	6700	110
Gelsemium,	nearly insoluble.	very soluble.

Under these circumstances the practitioner can hardly be blamed if he relies upon the alcoholic preparation in the belief that it will afford him very much more nearly the action of the drug itself. As a matter of fact, drug preparations are rated by the average physician, and wisely, according to their ability to produce results; and against the latter no amount of *a priori* reasoning has the slightest effect. It is the too-conservative who hold to the old, without due consideration for the

new. Change is the way in which all the world makes progress. It is through the law of variation that species best fulfill their environment. That which is best we call development; that which tends not to fulfill the requirements of environment we call degeneration. In life, all effort tends toward a better supply of any commodity in order to fulfill a given demand. This is progress. All physicians are in hearty accord with Dr. Carmichael, to hold on to that which is good; but if this laudable determination resolves itself into a firm decision to admit of no further progress in the preparation of therapeutic agents, we must disagree with him. In his contention that water is the great solvent we will agree in a general way, but it must be remembered that it is practically the blood of the plant, carrying into the stem, bark and leaves the substances which, in the physiology of plant life, form into organic compounds, which are deposited out of the circulatory stream, and are mostly insoluble in it. Therefore water is of no value for the purpose of dissolving out of root, stem or leaf the essential substances which give to them their value as drugs. This is, as a rule, far better accomplished by alcohol.

There exists a demand for active preparations of definite strength which can be used by the homœopathic physician for medicating pellets; and at last the modern pharmaceutical expert is endeavoring to meet the demand by placing at the service of the homœopathist that same knowledge which has done so much for the old school. In the case of these fluids which Dr. Carmichael so strongly detests, assay has shown that they represent a full proportion of the active drug. For example, a specimen of belladonna tincture, prepared by a representative firm of homœopathic pharmacists, and one of fluid belladonna, were recently submitted, without comment, to Mr. Frank X. Moerck, Professor of Analytical Chemistry in the Philadelphia College of Pharmacy. His assay showed that the first sample contained 0.0128 per cent. of atropin, while the second contained 0.0964 per cent.; or, in other words, *the alcoholic fluid represented nearly eight times the drug-strength of the watery tincture*. Similar high percentages of drug strength are revealed by the assay of a number of these fluids by Gilpin, Langdon & Co., of Baltimore, thus effectually disproving Dr. Carmichael's contention that water is the best drug-solvent.

Is the tincture the ideal representative, for therapeutic purposes, of the vegetable drug? That is the real question. Dr. Carmichael answers in the affirmative; and yet Dr. Carmichael acknowledges some very great objections to the use of his tinctures—notably that fresh-plant tinctures, up to the 2x dilution, cannot be poured upon pills or discs without dissolving them. In the same breath he condemns the fluids because strong alcohol is used, and water, “our greatest solvent,” is omitted; concluding that, therefore, there must be some loss of strength. To the unprejudiced outsider it must seem a curious intellectual perversion which persuades a man, on these grounds, to prefer a tincture which, according to his own statement, represents at best but one-tenth of drug-strength, and which cannot be used on pills until diluted ten or a hundred times over.

CYCLIC ALBUMINURIA.—Huger (Charleston, N. C.) reports with considerable detail two cases of cyclic albuminuria which came under his observation, and incidentally furnishes a very interesting *resume* of the later literature of his subject. He concludes that the cyclic albuminuria, like the recognized pathological albuminuria, is due to one, or perhaps all, of three causes:

1. Inflammatory and degenerative changes in renal structure, as evidenced by the finding of casts. There is every reason to think that, by careful searching, casts will be found far more often than previous reports lead us to believe.

2. Alterations in the quality of blood, which render its serum-albumin more diffusible. There is nothing to prove an inferior diffusibility in these cases, but the patients are almost always anæmic.

3. Alterations in the degree of blood-pressure; here due to a mechanically increased pressure on the renal veins.

Having learned that occasionally these cyclic cases pass into Bright's disease, but that by far the majority have gotten well and that many have been followed for years and then lost sight of, still in the same condition, it must be admitted that Moxan and Arnozan were right in dividing them into two groups: (a) Those few which develop a continuous albuminuria, and (b) the vast majority which get well. Continued rest in bed for a prolonged period should always be urged, because, at any rate, it removes the exciting cause. One of the writer's cases remained free from albumin for three months after being in bed for three weeks. He believes that, by a very careful examination for casts, a large percentage of cases will be found to contain them, and that the serious prognosis given because of their presence will be modified.—*Johns Hopkins Hospital Bulletin*, April, 1902.

EDITORIAL.

ALCOHOL.

FROM seeing alcoholic liquors used about us so generally as beverages, we have come to neglect the fact that, used medicinally, alcohol is a drug, and should be used with the same caution and understanding as any other of the drugs whose pharmacology shows that they possess power for harm as well as for good. Familiarity breeds contempt, and we continue to prescribe alcohol with a degree of carelessness which utterly disregards the inconsistency and danger which attend its use, according to the most recent and scientific investigations. Unfortunately, the results of the experiments to discover its action as a drug have in many cases proved contradictory, so that we have come to base our use of it upon traditional clinical experience alone, something which at all times, unless most carefully watched and controlled, is apt to mislead. It must be granted, however, that reliable clinical experience in therapeutics takes precedence of laboratory teaching, and it is no doubt owing to the recognition of this fact that we often find alcohol prescribed in conditions where, according to the pharmacology of the drug, it should prove not only not necessary, but even harmful.

The great diversity found in the results of laboratory experimentation can be traced to the different quantities employed in the experiments, and to the confounding of the symptoms of its primary and secondary actions, or of action and reaction.

The question has become further involved, even for the medical mind, by the ill-advised and extreme positions taken by the total abstinence, falsely called temperance, movements. The mixing of drinks is always to be deprecated, and morality and medicine should never be mixed. While a consideration of the possible result of the medicinal use of alcohol—the formation of the alcohol habit—should emphasize the necessity of caution in prescribing it, it should never be allowed to interfere

with a full appreciation of its legitimate sphere of action. All good things,—even the necessities of life, to say nothing of the luxuries,—if abused, are capable of producing harmful results; and, were this possible consequence to forbid their use, nothing would be left. The question which probably has been agitated the most is whether alcohol can be classed as a food, or must it be regarded solely as a poison. What is one man's food is another man's poison is true here as elsewhere, but in our opinion the recent investigations of Prof. Atwater have demonstrated that it is essentially a food. The professor, by means of the most exact experiments in his respiration-calorimeter, measured and analyzed not only all the food, drink, and excretory products, as well as the air which the occupant breathed, but also the potential energy of the food which the body received, and which it gave off in the forms of muscular work and heat. His experiments demonstrated that which we have always been so insistent in urging as a fundamental doctrine which does not generally receive the wide application of which it is capable, viz., "that the human body, like any other machine, obeys the laws of the conservation of energy." Giving the equivalent of about two and a half ounces of absolute alcohol daily, divided into six doses, he found that 98 per cent. was burned completely to carbonic acid and water, and 2 per cent. only was passed out from the body through the kidneys, lungs, and skin. The oxidation was as complete as in the case of bread, meat, or any other food, and, in the process, all the potential energy of the alcohol was transformed into muscular work or heat, as in other foods. He found, too, that the alcohol protected the material of the body from consumption just as effectually as the corresponding amounts of sugar and starch. It is, therefore, undoubtedly a food, and one which, under certain circumstances, where it is the only food which can be taken, can be used to take the place, temporarily, of other food stuffs.

An increase in the quantity taken may convert this food into a poison, or, through some idiosyncrasy of the individual, the smallest quantity may prove poisonous. Its additional properties as a drug, therefore, must be recognized and rationally applied. We use it as a drug in the treatment of disease; and, if there is any one thing demonstrated by clinical tests, it is that the effects of a certain unit or quantity of alcohol are not the

same in the states of health and of disease. In certain pathological conditions quantities of alcohol are used with benefit which, in a normal condition, would prove poisonous, if not fatal.

In order to have a clear understanding of the matter, we must regard our knowledge of alcohol as on a par with that of other drugs in our own *materia medica*, derived from provings by ourselves or others, and should, where possible, be guided in its use by the same principles which we apply to them. We have often thought that the benefit derived from our tinctures and dilutions was in many cases due as much to the homœopathicity of the alcohol to the condition as to the homœopathicity of the other drug in combination.

Alcohol in large or continued doses must be regarded as a narcotic or depressant, manifesting this character after a temporary stimulation of nerve-centres of shorter or longer duration. It has been found in the brain, when taken in excessive quantities, and in the laboratory it has been shown that its direct application to a nerve destroys its conductivity, while its vapor, after a preliminary exhilarating effect, produces paralysis of the nerve, from which, under favorable conditions, recovery may take place in a few hours. It has been found that the ability to do more work after the use of alcohol was a temporary result, and was only markedly increased when the body had a plentiful supply of nutriment. The ordinary use of this drug as a heart-stimulant for days at a time cannot, therefore, be regarded as rational treatment. It has no direct action upon the heart-muscle, except in quantities in the blood far in excess of any quantity the result of medical administration. The effect of the drug upon the heart and blood-vessels is the result of its action on the nerves controlling these organs. To act as a stimulant, it must be applied exactly in such quantities and at such intervals as to keep up the initial stimulation without allowing the depression to manifest itself,—as it were, by a summation of effects,—or homœopathically, *i.e.*, in small doses, to combat the symptoms known to be produced by large ones. The question of dosage is here, as elsewhere, a relative one; personally, we have had the best results—stimulation without subsequent depression—by what would appear as ridiculously small quantities—ten to twenty drops of undiluted

liquor. It is a strange, but not altogether inexplicable fact, that those who are inclined habitually to use alcohol, as well as other heart-stimulants, find so many more cases requiring such treatment than do those who do not have recourse to them so readily. May it not be that the too early use produces the very condition which it is intended to combat, and that recovery takes place despite, and not in consequence of, the treatment? Keeping in mind the retrograde changes shown by Stewart to take place in the nerve-cell substance from the long-continued use of alcohol, more caution should be exercised in its administration as a stimulant.

By its irritant action upon the mucous membrane of the mouth and stomach it has a distinct effect in stimulating the secretion of saliva and of the gastric juice, and in exciting an appetite. It is readily absorbed from the stomach, and increases the absorption of other soluble substances, and therefore, in certain conditions and in certain doses, it may be beneficially employed. It has, however, in certain strengths, a retarding effect upon the action of the proteolytic and amylolytic enzymes, a fact which will contraindicate its routine employment as a stomachic. Its long-continued use in large quantities our daily clinical experience shows to be attended with serious lesions in the stomach and liver.

As a narcotic its use may occasionally be justifiable, but the danger of originating an alcohol habit, especially in the class of patients most frequently calling for narcotics, and the actual degenerative changes in the nerve-cells from its long use, should make us hesitate before employing it in this way. We have not intended to preach a temperance crusade in the above, but have endeavored to justify a demand for the more scientific employment of this potent drug. Used by the physician—in his practice—it should be regarded as a drug to be prescribed with the same care and according to the same principles of practice as other drugs, with a full recognition that it is potent for evil as well as for good, and *vice versa*.

Furthermore, and finally, we throw out the idea that perhaps we homœopaths may yet find in alcohol not merely an indifferent medium for making tinctures and dilutions, but a powerful remedy, used according to our law, for the treatment of symptoms resembling the effects of chronic alcoholism.

RIP VAN WINKLE AT THE HELM.

OUR attention has been directed to the following correspondence :

PHILADELPHIA, April 16, 1902.

JOHN MARSHALL, M.D., *Dean of Department of Medicine, Univ. of Penna.*

Dear Doctor: Seeing the announcement of the Post-Graduate Course in Medicine to be given at the University this spring, I ask you to kindly send me a roster and the terms for the various courses. I am a graduate of Hahnemann College of Philadelphia, 1900, and am anxious to do post-graduate work in clinical medicine and pathology.

Truly yours,

J. R. ROCHESTER.

UNIVERSITY OF PENNSYLVANIA, DEPARTMENT OF MEDICINE.

OFFICE OF THE DEAN,
JOHN MARSHALL.

PHILADELPHIA, April 17, 1902.

Dear Doctor: In reply to your letter of April 16th, I would say that the post-graduate course which is to begin early in May is designed for graduates of regular school of medicine.

Very truly yours,

To Dr. J. R. ROCHESTER.

JOHN MARSHALL.

Were not the documents of which the above is a copy before us, we would not believe that such a sample of bigotry could be found in Philadelphia or elsewhere. And yet we ought not to be surprised at anything in this line perpetrated at the Institution beyond the river. Several years ago, the Young Men's Christian Association endeavored to interest the medical students of Philadelphia in their work, and organized reunions, and planned for an annual parade, the head of the line being taken by the different colleges in turn. The University students led the procession the first year. Everything was lovely. Next year, the University men were relegated to the rear, and the Hahnemann men went up front. Then the U. P. men positively refused to play, and the scheme was abandoned. Worse than that! They behaved like rowdies, and attempted to mob our students.

Within a year, one of our rising young men was taking a

special course in one of the laboratories, and owing to his ability and push was shown many courtesies, when the identity of his college was disclosed. He then received a letter returning his fees and requesting him to discontinue his visits.

And now comes this from the Great and only Dean of the great and only institution of learning! And to think that the taxpayers are expected to lend their support to such bigotry. Worse than that! It was only a short time since that we were favored personally with a circular letter from the Provost soliciting our aid in the erection of a new building for the medical school. We believe that we were not alone among the homœopathic physicians thus favored with a request for a contribution.

It is mortifying to us, as citizens of Philadelphia, to think that the University of Pennsylvania has the ignominy of standing alone as the only college in the country refusing to take homœopathic graduates as students. It was only a few years ago that the Association of American Medical Colleges ruled that it was proper to accept for advanced standing students from any college, if found qualified on examination.

The narrow intolerance of the Institution as a whole appears to extend to its representatives in faculty and alumni, for not long since one of its professors organized an attempt at black-balling a prominent homœopathist in his desire to prevent the admission of said homœopath to membership in said club. Explaining his position to a friend, one of his lieutenants said, "You know there are two kinds of brokers: regular brokers, and the bucket-shop fellows. We are the regulars. They are the bucket-shops." And the same thing is happening right along in our Philadelphia clubs, as others can testify.

Surely, the lamb cannot lie down with the lion in safety!

A CASE OF TABES DORSALIS IN A CHILD.—Dr. Koester reports the case of a child who, formerly suffering from interstitial keratitis, and where the father had probably been infected with syphilis, at the age of thirteen years complained of lancinating pains in her legs, which continued for five years. The acuity of her vision decreased in the fifth year of her disease, which gradually went on to complete blindness. Ophthalmoscopically typical atrophy of the optic nerve was observed. The patient, at present eighteen years old, who has been for five years under his observation, has lost the patellar reflexes, is moderately ataxic, and slightly analgesic in both legs.—*Muenchener Medicinische Wochenschrift*, No. 8, 1902.

SOME HOSPITAL STATISTICS.

"THE following table is made up from official reports. The numbers in the first column refer to those hospitals of a large American city which treated over 10,000 patients in 1900 :

Hospital No.	In-patients.	Out-patients.	Total patients.	Total Running Expenses.	Cost per patient.
One, .	1854	8,197	10,051	\$107,079.37	\$10.65
Two, .	1894	11,810	13,704	105,635.16	7.71
Three, .	3850	12,559	16,409	83,410.03	5.08
Four, .	901	11,433	12,334	53,787.05	4.36
Five, .	3026	34,110	37,126	125,939.43	3.39
Six, .	4079	30,860	34,939	116,790.30	3.34
Seven, .	4654	15,674	20,328	64,056.22	3.15
Eight, .	973	14,608	15,581	34,717.45	2.23
Nine, .	1206	24,011	25,217	53,372.86	2.12
Ten, .	745	23,666	24,411	45,813.40	1.87
Eleven, .	2052	18,614	20,666	37,781.17	1.83
Twelve, .	1898	34,281	36,179	63,378.79	1.75

"Perhaps one of the most common-sense ways of calculating the value of a hospital to the community in which it is situated is by finding the number of citizens it has been able to restore to health and usefulness. The figures in the table make one wonder why the cost per capita in one great hospital is five or six times as much as in another. The relatively greater cost of in-patients is a factor, but the discrepancy is by no means thus wholly accounted for. The dispensary abuse has been much criticized, but has the other side of the question had a deserved emphasis? Is not the hospital which treats its patients in the dispensaries as far as possible, and which keeps down the average stay in the wards to the lowest number of days consistent with the safety of the patient, doing a practical work which the hospital is likely to forget that retains its patients longer than may be really required? Do we think that every time a wage-earner is admitted to the wards of a hospital his income-producing ability ceases at once, and the hospital may thus become a pauperizing agency, if it were possible just as safely to produce the same result by treating the applicant as a walking case and allowing him to resume at least partial labor? Do we always think of the wife and children who are deprived of support when the head of the family is told that he must enter a ward? Does the desire for clinical material sometimes influence more than the comfort of those dependent upon the sufferer? This is a great problem, and abuse must not be considered as being all on one side. Improperly conducted, the

dispensary may become an influence for evil instead of good; but when rightly managed, may it not, in reality, 'help the poor to help themselves?'—*American Medicine*, March 29, 1902.

Though it would not be suspected by the casual reader, the above editorial contains a carefully concealed compliment to the methods and management of a homœopathic institution. A key to the statistics is found in the last report of the Board of Public Charities, which furnishes the following figures of the work accomplished by the great hospitals of Philadelphia during 1900:

Hospital.	In-patients.	Out-patients.	Total patients.	Total Running Expenses.
Presbyterian, .	1854	8,197	10,051	\$107,079.37
University of Pa.,	1894	11,810	13,704	105,635.16
German, . . .	3850	12,559	16,409	83,410.03
Jewish, . . .	901	11,433	12,334	53,787.05
Episcopal, . .	3026	34,100	37,126	125,939.43
Pennsylvania, .	4079	30,860	34,939	116,790.30
Jefferson, . .	4654	15,674	20,328	64,056.22
Germantown, .	973	14,608	15,581	34,717.45
Medico-Chirurgical,	1206	24,011	25,217	53,372.86
Polyclinic, . .	745	23,666	24,411	45,813.40
St. Joseph's, .	2052	18,614	20,666	37,781.17
Hahnemann, .	1898	34,281	36,179	63,378.79

ICHTHYOL IN GRANULAR CONJUNCTIVITIS.—Dr. Popov, on account of ichthyol being recommended by Jecovides and Bielevitch in catarrhal and phlyctenular conjunctivitis and trachoma, has employed it with good results in granular conjunctivitis. He employs it in 10–20 per cent. solutions as a collyrium. He everts the lids and drops onto them the solution of the drug in water, leaving it there until the sense of burning begins to disappear, when the excess is wiped off with a tuft of cotton. He has treated thus thirty cases, of which six had incipient trachoma, one dry granular conjunctivitis without catarrh of the conjunctiva, seventeen chronic trachomatous conjunctivitis, with diffuse infiltration and hypertrophy of the conjunctival sac, accompanied by very profuse muco-purulent secretion. The first class of patients were cured in two to five weeks. The dry form required a month and a half. The patients of the third group were cured in two months. Of those with hypertrophy of the conjunctiva, four were definitely cured in four months, and in the thirteen others there was considerable improvement, with diminution of the muco-purulent secretion and of the thickening of the conjunctiva, as well as by the appearance of little islets of healthy conjunctiva.

The instillations are but little painful, and less so than those of the nitrate of silver or of the sulphate of copper. In one case he noted a peculiar idiosyncrasy towards the drug manifested by œdema of the conjunctiva.—*La Semaine Médicale*, No. 11, 1902.

GLEANINGS.

THE RELATION OF PELVIC DISEASE TO INSANITY.—(Hobbs.)—The result of pelvic examination of a large proportion of the female population at the Asylum for Insane, London, disclosed at least the presence of organic disease or abnormalities in 25 per cent.

The gynæcological examinations were conducted uniformly, with the aid of an anæsthetic. Experience showed that the best anæsthetic for the insane was ether, preceded by the inhalation of nitrous oxide gas. This is the only reliable method of making such examinations in the insane.

Two hundred and fifty-three out of one thousand females resident in the institution during the past six years had some pelvic disease or abnormality requiring treatment. The only success obtained was by surgical means.

Forty-one cases were treated for disease of the ovaries and tubes. There were seven hysterectomies and twenty-five single or double oöphorectomies, and in nine cases a part of one or both ovaries was preserved after removal of the diseased portion. There were two deaths from pneumonia. The time of mental recovery varied from three months to one year. The results are classified as follows :

	Cases.	Recoveries.
Acute mania,	11	7
Chronic mania,	23	9
Epileptic mania,	2	0
Folie circulaire,	2	1
Psychoma,	1	1
Acute melancholia,	3	2

This gives 49 per cent. of recoveries. The duration of the insanity in these twenty cases averaged eighteen months. Besides this, there were ten patients, or 25 per cent., who showed distinct mental improvement, though the average duration of insanity in three cases exceeded three years.

There were sixty-six cases of abnormally displaced uteri which were operated on, mostly by shortening the round ligaments and by ventral suspension. The synopsis of the mental condition is as follows :

	Cases.	Recoveries.
Acute mania,	26	15
Chronic mania,	22	3
Epileptic mania,	1	0
Puerperal mania,	7	4
Acute melancholia,	9	5
Chronic melancholia,	1	1

This shows a recovery of the mental condition in 42 per cent. of the cases, with an average duration of the insanity of one year and ten months, and 23 per cent. showed improvement.

Sixteen patients suffered from some form of tumor or new growth. The results of operation on the mental condition were the following:

	Cases.	Recoveries.
Acute mania,	1	1
Chronic mania,	11	1
Epileptic mania,	1	0
Chronic melancholia,	3	3

Only 12 per cent. of these cases recovered reason.

The cervix was injured or diseased in sixty cases. The usual operations were performed, with restoration to bodily health in all. The mental condition resulting was as follows:

	Cases.	Recoveries.
Acute mania,	17	12
Chronic mania,	30	5
Puerperal mania,	3	0
Epileptic mania,	1	0
Folie circulaire,	2	0
Chronic melancholia,	3	1
Acute melancholia,	4	0

There was complete mental relief in 31 per cent. of the cases, with an average duration of insanity of fifteen months, and 23 per cent. improved mentally.

Disease of the uterine body or the endometrium required curettement in fifty-two cases, with the following results mentally:

	Cases.	Recoveries.
Acute mania,	23	14
Chronic mania,	15	1
Puerperal mania,	3	2
Acute melancholia,	5	3
Chronic melancholia,	4	3
Puerperal melancholia,	2	2

The mental recovery rate was 48 per cent., and besides this, 21 per cent. showed mental improvement, their insanity averaging three and one-half years. Heredity showed itself in 29 per cent. of the fifty-two patients so treated.

Lacerations of the perineum was the main injury in eighteen patients, and were treated surgically in the usual way, with the following results:

	Cases.	Recoveries.
Acute mania,	6	2
Chronic mania,	4	0
Puerperal mania,	2	1
Acute melancholia,	4	3
Chronic melancholia,	2	1

Thirty-nine per cent. recovered mentally, and 17 per cent. improved whose duration of mental enfeeblement exceeded nine years.

The pelvic lesions having the greatest effect upon mental alienation were those in which there existed changes in the ovarian structure causing an interference with ovarian function; the next most potent factor was disease

of the uterus, and the third was injuries to the vagina. New growths were of the least importance. In the acute mental affections the recoveries from mania took the lead, with a percentage of 61; then melancholia, 58 per cent., and puerperal insanity, with 53 per cent. Chronic melancholia gave much better results than mania—46 per cent. of the former to 25 of the latter. None of the epileptics recovered. A comparison of the official statistics of the London Asylum before and after the institution of gynæcological surgical treatment is of interest.

These show that for the biquinquennial period previous to such treatment, the average annual rate of discharges of patients recovered and improved, calculated on the admissions, was, for the male residents, 35.23 per cent., and for the female, 37.5 per cent.

For the third quinquennial period, during which gynæcological surgery was employed in addition to the ordinary methods of treatment, it was found that the annual rate of discharges among the men differed very little from that of the previous two quinquennials, being 35.92 per cent. The women, however, during this same period had advanced from 37.5 to 52.7 per cent., or a gain in the discharge rate of 35 per cent., which was certainly due to the surgical treatment of their pelvic diseases. An examination of the readmissions showed the same, *i.e.*, an equal number for each sex, which verifies the stability of the treatment.—*American Journal of Obstetrics*, February, 1902.

George R. Southwick, M.D.

THE SIGNIFICANCE, PATHOLOGICAL AND CLINICAL, OF ABDOMINAL PAIN.—W. H. Richardson (Boston) concludes a notable discussion of the above topic as follows:

When a patient has been seized with sudden, severe abdominal pain—

(1) The pain should not be masked by opiates before the surgeon has an opportunity to see the patient.

(2) The previous history, accompanying symptoms, and physical signs must be carefully considered.

(3) Careful examination of the thorax and abdomen in all cases of pain should never be omitted.

(4) When hæmorrhage is suspected, the abdomen should always be explored. If the patient is in collapse, and the pulse apparently too weak to allow the patient to undergo exploration, preliminary infusion of salt solution should be made into the veins or under the skin.

(5) When the pain is excruciating, and the abdomen shows signs of infection, exploration should be made at the earliest possible moment.

(6) The seat of the initial pain, as described by the patient and his friends, is a good guide to the incision, when, from other symptoms, the surgeon is in doubt.

(7) The history and signs, other than pain, must be relied upon for exact or reasonably positive diagnosis.

(8) When some of the rarer abdominal lesions are suspected, exploration should nevertheless be made. Such an exploration may be useless, but if resorted to as a routine procedure in all cases, the greatest possible number of lives would be saved.

(9) When there is the least question, the genuineness of the pain should be tested as thoroughly as possible.

(10) The pain of an atypical typhoid, of a pleurisy, of a pneumonia, must be guarded against. When typhoid is prevalent in a community, the greatest care must be taken, lest the surgeon be misled by the pain of such a case.

(11) The observer must be on his guard, lest he confuse the pain of simple functional disturbances with that of organic disease; he must rely upon the accessory signs of the organic lesion.

(12) When in grave doubt as to the significance of pain and other symptoms, the benefit of the doubt should be given the patient by surgical exploration.

(13) Finally, when no exploration is regarded as justifiable, pain should be controlled by morphia, by hypnotics; or, if necessary, by general anæsthesia. With very few exceptions, however,—chiefly cases of renal and biliary colic,—the pain that demands general anæsthesia demands operation.—*Boston Medical and Surgical Journal*, February 27, 1902.

F. Mortimer Lawrence, M.D.

THE ETIOLOGY AND DIAGNOSIS OF ACUTE PANCREATITIS.—An editorial in the *Medical News* (January 8, 1902) on the diseases of the pancreas notes that some of the latest American observations are eminently suggestive, and promise to be of great practical service. Flexner has confirmed Flava's observations with regard to the probable etiological rôle played by acid gastric contents in the production of acute pancreatitis. This disease occurs especially in alcoholic patients whose gastric juice is liable to be overacid. In such patients, regurgitation of the gastric contents into the pancreatic gland through its duct might lead to acute inflammation of the pancreatic substances, and such regurgitation is not impossible under the stress of the antiperistalsis that often accompanies severe vomiting. Flexner further has shown experimentally that the ingestion of artificial gastric juice into the pancreatic ducts is liable to set up acute pancreatitis. Certain European observers point out the fact that an overflow of bile into the pancreas may take place under certain pathological conditions, and that this is liable to set up acute hæmorrhagic pancreatitis. An important pathognomonic sign of pancreatic involvement seems to have been recently discovered by Opie, who found in the urine of a patient, dead from acute pancreatitis, a fat-splitting ferment. This discovery has not been confirmed, but no such ferment can be found in other urines.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF GOUT.—Tyson (Philadelphia), after reviewing the newer theories as to the source of uric acid, remarks that these newer views have not influenced the treatment of uric-acid conditions materially. Unlike Duckworth, he has found the salicylates decidedly beneficial in acute gout. An abundance of alkaline water, especially between meals, or, in the absence of alkaline waters, of plain water, and the exclusion of proteid foods to a degree sufficient to eliminate uric acid from the urine, accompanied by a liberal amount of out-door exercise, is to-day, as for some time past, the treatment of the uric acid diathesis in whatever form it manifests itself. Moreover, as the condition constitutes, as it were, a peculiarity of the individual which, while capable of being held in check, is scarcely eradicable—especially in hereditary cases—the treatment must be kept up for a long time, indeed, in certain cases never interrupted, except for a short time, for the condition

is almost sure to reassert itself. For articular deposits and swellings, massage is the most valuable treatment, especially when taken in connection with warm baths.

From the standpoint that uric acid is solely the product of excessive leucocytes, and that its accumulation in the blood arises from this cause rather than defective renal function, the following outline of treatment recommended by Croftan (*Journal of the American Medical Association*, July 8, 1899) is representative:

There are two indications: (1) A reduction in nuclein catabolism; (2) a raising of the processes of oxygenation. To attain the first object, everything should be avoided that will produce a leucocytosis. To this end, a number of drugs, such as quinine, pilocarpine and atropine, should never be administered, and certain articles of diet that we know produce leucocytosis—notably proteids—should be reduced. Nuclein-containing foods, such as sweetbreads and other internal organs, and yolk of egg, should be avoided. Overeating should be forbidden. “In a true uric-acid case there will be excessive nuclein catabolism, despite all we may be able to do, in the very nature of the taint, and restrictions in diet will not be of permanent benefit; the chief point of attack will be in the direction of raising oxidation. A uric acid case should be treated as an anæmic case in all measures employed to promote the oxygenation powers of the blood,—i.e., the production of an increase in the red blood corpuscles and of the hæmoglobin and its chief oxygen carrier—iron.” Iron should be administered in the forms and on the same rational principles as it would be to a chlorotic patient. Arsenic should therefore be combined with it. Whatever medicinal and hygienic measures tend to a successful aeration of the blood should be employed. Accordingly, Dr. Croftan says, the most striking results have been obtained in acute cases by inhalations of oxygen gas. On six occasions he claims to have aborted an attack of gout by inhalations of oxygen repeated at short intervals. He believes, too, that he can invariably relieve, if not cure, a uric-acid headache, a migraine, in short, lithæmic attacks, by oxygen inhalations.—*N. Y. Med. Journ.*, March 15, 1902.

F. Mortimer Lawrence, M.D.

THE EXTENT OF GASTRIC DIGESTION IN CASES OF CARCINOMA OF THE STOMACH.—Emerson, in a preliminary note to the Johns Hopkins Medical Society from the clinical laboratory of Prof. Müller, at Basel, Switzerland, tells of a series of analyses of gastric contents calculated to ascertain if anything characteristic could be discovered in cases of carcinoma. The results are very interesting, inasmuch as they tend to show that in carcinoma digestion is more advanced—i.e., more of the albumin being found in a stage beyond that of albumoses than in the normal, hyperacid and antacid stomachs. This would confirm the opinion formerly held by Prof. Müller, that in the carcinomatous stomach the carcinoma itself furnishes a ferment which aids in the peptic digestion.

Hemmeter, discussing the report, stated that it impressed him as a *resume* of the hypotheses attempting an explanation of why the carcinomatous stomach contains less hydrochloric acid than the normal stomach, and then an effort to establish one of these explanations on a more solid basis by chemical investigation. It is unfortunate (for the theory that the neoplasm gives

rise to something which neutralizes the secreted HCl) that the carcinoma which originates from a gastric ulcer has an excess of hydrochloric acid, and yet, according to Hauser, it presents the architecture of a typical carcinoma. Then, too, it makes a great difference where the carcinoma is located. Hydrochloric acid is a product of well-defined histological elements in the peptic ducts, and these oxyntic cells are limited to a particular zone in the stomach. If the carcinoma should originate where there are few of these cells, it is logical to presume that it would not interfere so much with the formation of hydrochloric acid; so we are justified in considering that the absence of HCl in carcinoma rests upon this histological basis, rather than upon the hypothesis that the carcinoma produces something by which the HCl is neutralized. Dr. Emerson states that digestive experiments with cancerous stomachs indicate that the solution of proteids is carried a little farther than in normal stomachs; but this is too sweeping a statement, for there are carcinomatous stomachs which secrete no HCl, pepsin, or rennin, or the prozymogens of these ferments, whatever. Whatever change takes place in such stomachs must be due to bacteria.—*Johns Hopkins Hospital Bulletin*, April, 1902.

F. Mortimer Lawrence, M.D.

THE DIAGNOSTIC VALUE OF THE WIDAL REACTION.—Libman (New York), as a result of his experience as assistant pathologist of Mt. Sinai Hospital, concludes that:

1. A positive Widal reaction always means that typhoid is or has been present.

2. Partial reactions are absolutely to be ignored.

3. A negative reaction does not exclude the existence of typhoid fever. It occurs under any of the following conditions: (a) The reaction has already disappeared; (b) the reaction may only appear later; (c) the culture may be at fault; (d) the case is clinically one of typhoid fever, and there may never be a positive reaction; (e) the disease is not typhoid fever. A negative reaction may occur if the patient is suffering from an infection by a paracolon bacillus, and still, for the practitioner, the case is identical with one of typhoid fever. Again, a positive reaction may occur when the case is clinically not typhoid fever, and yet the autopsy, if there be one, may show the presence of the typhoid bacillus in some part of the body, or it may be found *intra vitam* in the urine, feces, rose spots, blood, or some complicating lesion.

4. Scientifically, the Widal reaction is of the greatest value in establishing the presence of infection by the typhoid organism in cases such as those last referred to, and in assisting in identifying the typhoid bacillus. Practically, it is also of great use, but it is not so valuable as we would wish it to be. Often the diagnosis of typhoid fever is very clear long before we obtain the reaction. In many cases, however, it alone can establish the diagnosis. This is particularly true of the atypical cases in which pneumonic or meningeal symptoms usher in the disease. These cases are more common in children than in adults.—*Medical News*, March 29, 1902.

F. Mortimer Lawrence, M.D.

SUBCONJUNCTIVAL INJECTIONS OF GELATIN.—De Wecker, noting the remarkable results of gelatin injections in aneurysms of the aorta, has been led to employ the same material either alone or in combination with 3 to 5 per cent. strength solutions of chloride of sodium subconjunctively, instead

of the painful injection of 10 to 20 per cent. strength solutions of salt. He speaks encouragingly of this method of modifying the osmotic currents, more particularly in cases of intra-ocular hæmorrhage. An example of this affection is reported.

The patient, from frequent hæmorrhages into each vitreous humor, had the vision of the right eye reduced to poor perception of light, and that of the left eye to fair light perception. No retinal reflex was obtainable. With oblique illumination the extravasated blood was visible just behind the crystalline lens.

After six weeks' treatment with bi-weekly injections of a syringeful of a 2½ per cent. strength of gelatin solution, vision with the right eye arose to one-tenth of normal, and with the left reached nearly one-fourth. One year later the treatment was repeated, bringing the vision to one-sixth of normal with the right eye and one-half of normal with the left.

The fundus of the eye could be easily seen, and showed the remains of proliferating retinitis, while that of the right eye remained veiled by a haze in the vitreous chamber.

The author has found that the injections are painless, and that they are not followed by any reaction, if properly sterilized solutions of isinglass, and not bone gelatin, are used. He states, however, that if these conditions cannot be fulfilled, it is far preferable to employ simple chloride of sodium solutions, which are easily rendered aseptic. De Wecker, Paris.—*La Clinique Ophthalmologique*.

William Spencer, M.D.

CONCERNING THE VALUE OF ELECTROLYSIS IN THE TREATMENT OF RETINAL DETACHMENT.—Maraval disbelieves in the tentative treatment of retinal detachment, having found that electrolysis serves as the most valuable therapeutic means. The puncture of the needle, he says, allows a partial escape of the serous exudate, favors the formation of adhesions, and increases the general ocular nutrition.

He employs a five to a five and a half milliamperé current, passed for one minute's time, and controlled by a rheostat. In addition to the electrolysis, he makes use of subconjunctival injections of bichloride of mercury in solutions of 1 to 1500 or 1 to 2000 strength. These, he says, should be commenced four days after the use of the electrolysis. The injections seem to maintain the effect of the electrolytic action. After the employment of electrolysis, a compress bandage is to be applied. It should be employed for four days' time. The patient is to be confined to his bed for a period not exceeding six weeks.

The electrolytic procedure may be repeated, the author having applied it three times in one case. Ten cases are reported, two having been cured and the remainder much benefited. None of them were of more than one month's duration. Maraval, Oran.—*La Clinique Ophthalmologique*.

William Spencer, M.D.

TREATMENT OF AFFECTIONS OF THE LACHRYMAL PASSAGES BY MEANS OF SOUNDS OF GELATIN PROTARGOL.—Antonelli has found that sounds of gelatin protargol are effective in affections of the lachrymal passages. For their use a more or less complete section of the canaliculus is indispensable, and a stricturotomy is often useful. Gelatin is the preferable excipient, because of

its strength, its flexibility, and its solubility. The sounds ordinarily employed by him are equal in size to No. 4 calibre. They are introduced after the withdrawal of a No. 5 or 6 metallic sound. He has found that the results obtained by these sounds are undoubtedly better than those that are gotten by injections of protargol or other substances. He believes that this is due to the fact that there is a prolonged contact and some peculiar diffusibility of the organic salt of silver. He has employed sounds containing even 50 per cent. of protargol, and has found that they are well borne. Antonelli, Paris. —*Annals d'Oculistique*.

William Spencer, M.D.

THE TONSILS AS PORTALS OF INFECTION.—After a thorough *resume* of the literature on this subject, the author draws the following conclusions :

That the normal tonsils have a physiologic function, probably protective to the organism.

That, being in itself often diseased, the physiologic function of the tonsil is impaired, and that, instead of being protective, it is the nidus for the growth and distribution of pathogenic organisms and their poisonous products in the system.

That many grave and fatal general infections have their origin in the tonsils.

That if the exanthemata, particularly scarlatina, are of bacterial origin, the tonsil acts in part as the port of entry.

That acute articular rheumatism, and the diseases often associated with it, endocarditis and chorea, in the great majority of cases, are due to the action of attenuated bacteria, their toxins, or both, entering the system through a diseased tonsil.

That in those rare cases of typhoid fever in which no intestinal lesion can be demonstrated, the similarity of the tonsillar tissue and Peyer's patches suggest the tonsil as the portal of entry of the Eberth bacillus.

That scrofulosis is often associated with the diseased tonsillar tissue, and that the tubercle bacillus often enters the system via the tonsils.

That the tonsil is too little examined at autopsy, and much light might be shed on fevers of uncertain origin by its bacteriologic and histologic examination.—Dr. Uhlman, *Medical News*.

William Spencer, M.D.

CATARACT EXTRACTION IN EXTREMELY ADVANCED AGE.—Reclination in advanced age has been almost entirely supplanted by extraction. Mendel, the second assistant at Hirschberg's clinic, observed that, of the thirty-four patient's over eighty years of age among the 1645 in whom nuclear cataract was extracted, unfavorable results were obtained in but one case.

In individuals over eighty years of age, a corneal section constitutes not only an exquisitely delicate procedure, but one coupled with many difficulties, such as atrophic thinning of the tissues, arteriosclerosis and constitutional involvements, embracing the lungs, heart, genito-urinary system, and even the brain. Complications, such as prolapse of the iris, loss of vitreous, and infection, are necessarily more liable to occur, and in one of Mendel's cases pulmonary œdema followed a cataract extraction.

With scrupulous care, however, extreme old age does not materially influence the prognosis of cataract extraction.—*Phila. Med. Jour.*

William Spencer, M.D.

"INTERNAL DERANGEMENT" OF THE KNEE-JOINT. —Allingham (London) says that a considerable variety of lesions in the knee-joint may all cause the symptoms common to cases known as examples of "internal derangement." Not only a displaced cartilage, but one that is split, or a laceration of the alar ligament, can cause these symptoms. Moreover, some cases present these symptoms and improve after the joint is opened, although no lesion at all is discerned. The operation acts curatively, just as it does in those cases of pain and discomfort in the abdomen in which the symptoms disappear after a laparotomy. Possibly some of these cases may represent very early instances of tuberculous affection of the synovial membrane. The term "internal derangement" of the knee, then, does not necessarily mean a lesion of one of the semilunar cartilages. The symptoms that the author calls attention to are the classical ones. A blow or twist of the knee followed by fixing of the joint for a time, great pain and rapid swelling. Perhaps something is felt to move or lock in the joint, and on replacement the joint can be moved again. In such a case, the early treatment is of the utmost importance—splinting for a period varying from one to three weeks, so that the damage may heal, followed by massage, passive movements, and properly selected exercises to restore the supporting structures of the joint, with a view of preventing recurrence. Cases where there is recurrence, and especially those that have had repeated attacks, require operation. The strictest asepsis must be observed. The joint, in absence of other indications, is opened by a vertical incision of three inches in length, one inch to the inner side of the patella, and going down to an inch below the head of the tibia. It should not be washed out with antiseptics, and no drainage should be employed. When necessary, the finger should be used to examine every part of the joint that can be reached, and occasionally flushing with boiled water will float out a foreign body that has evaded the finger. The author favors removing loose semilunar cartilages, rather than fixing them; and the same applies to torn or hypertrophied alar ligaments or local hypertrophy of synovial membrane.

In the after-treatment the author recommends removal of the splints within a week. Passive movements are begun as soon as the skin-wound is healed, and are combined with massage. If, in spite of exercises and massage, there appears some stiffness of the joint, it must be freely moved under an anæsthetic, and then daily massaged and freely moved to prevent stiffness from reappearing. The author appends a tabulated list of 59 cases in which the knee-joint was opened for "symptoms of internal derangement." The internal semilunar cartilage was removed 22 times, fixed 12 times. In 12 cases loose cartilages were removed. The alar ligament was removed in 1 case and fixed in 1. In 7 cases chronic traumatic or rheumatoid arthritis was found, and in 3 cases there was nothing found.

The author emphasizes the fact that there is considerable risk in the operation, and it should be considered a serious one. Two of his cases resulted in permanent stiffness. In two others convalescence was prolonged by excessive secretion of synovia, and a tendency to stiffness that was hard to overcome. Eventually they both had perfect function.—*The Lancet*, March 15, 1902.

Gustave A. Van Lennep, M.D.

PROSTATECTOMY BY THE PERINEAL ROUTE. — Syms (New York) advocates prostatectomy performed through the perinæum, and without opening the bladder suprapubically, as safer than the procedures which do involve suprapubic cystotomy. He also suggests opening the abdomen above the bladder fold without incising that organ, whereby the prostate, bladder and all, could be pushed towards the perineal wound, and so facilitate enucleation. This suggestion has been modified by Johnson, who makes an opening into the prevesical space below the peritoneal fold (the first step of suprapubic cystotomy), introduces his finger, and pushes the unopened bladder towards the perinæum. In his operations the author makes use of a specially constructed bladder retractor, which does away with the necessity of pressure from above. The instrument consists of a rubber tube of a calibre of 38, French scale, having a rubber bulb attached to one end, which can be dilated when it is introduced into the bladder. Through a median perineal incision the membranous urethra is exposed by dissection backward until the tip of the prostate is reached. An opening about an inch in length is made into it, the bladder is irrigated, the prostatic urethra dilated, and the retractor, collapsed, is introduced through the opening well into the bladder. The bulb of the instrument is then dilated to a diameter of two and a half inches by injecting two and a half ounces of water through the tube by means of a piston syringe, and the end of the tube clamped. Firm traction is made on this tube, and then it is turned up over the perinæum and held there by an assistant. This fixes the neck of the bladder and prostate, and prevents it from receding; then the capsule of the gland is entered and the lobes are enucleated by the index finger. In place of Syms's rubber retractor, Gouley's prostate depressor may be used.

These patients are usually out of bed anywhere from the seventh to the tenth day. In none of the author's thirteen cases has there been any stricture following the operation. All are able to control their bladders, to empty them voluntarily, have no cystitis, no frequency, no pain, and no irritation. The author strongly advises that when prostatectomy is to be employed, it should be done early, and not left as a last resort. — *Annals of Surgery*, April, 1902.

Gustave A. Van Lennep, M.D.

A SERIOUS CASE OF OPIUM POISONING IN A SEVEN MONTHS' OLD CHILD, FOLLOWED BY RECOVERY. — Dr. N. Feuerstein, of Bukowina, was called to a child of seven months, to whom the nurse had, by accident, given a teaspoonful of tincture of opium instead of syrup of rhubarb. Given at six in the morning, the accident was concealed until, the condition of the child becoming alarming, he was called at nine.

Then the little patient was cyanotic, both in its face and whole body, its head drawn back, its eyes protruding, its arms extended, its fingers clasped spasmodically into the palms. The pupils were greatly contracted, and it made movements with its mouth as though it were nursing. Its pulse was scarcely to be felt, the respiration superficial, and each inspiration accompanied by an audible crowing sound. The reflexes were abolished; the cornea was insensible to contact. No time was to be lost, and a soft catheter of small calibre was thrust through the right nostril into the stomach, its reaching the stomach being confirmed by a curdled, brownish fluid like milk, colored with tincture of opium, pouring out of the end of the instrument. Warm water was then injected, followed by a weak solution of the permanganate of potash,

and this continued until the fluid issued clear. No improvement setting in, a warm bath with cold affusions was next tried, when consciousness returned. A few enemata of a weak solution of the permanganate were administered, to be followed by copious stools. A few teaspoonfuls of hot coffee and wine were given; the child fell asleep, and seemed better. These measures were repeated several times during the day, and that evening the child was still sleepy, but could be awakened. The pulse and respiration were satisfactory. The cyanosis, spasm of the glottis, and the rigidity of the neck had disappeared. It took the breast, and passed a good night. The next day it was out of danger.—*Wiener Medicinische Wochenschrift*, No. 5, 1902.—(The result certainly must be attributed to the promptness with which the stomach was washed out and the use of the solution of permanganate of potash, which also is a valuable chemical antidote in poisoning by phosphorus.)

Frank H. Pritchard, M.D.

MALIGNANT DISEASE OF THE TONSILS.—Dr. Hopkins has found such growths of the tonsils to be rare. Carcinomas soon undergo ulcerative changes, while sarcomas remain unchanged until, by mechanical irritation of the surrounding parts, they may become ulcerated. At first their growth may be confused with simple hypertrophy. A sarcoma seems to infiltrate posteriorly towards the back of the neck, while sarcoma more readily invades the tongue, and earlier gives rise to pains than a sarcoma, which at first acts only mechanically. An early diagnosis is by no means easy, for he cites cases where, in spite of a most careful examination, even under the microscope, a sarcoma was assumed to be present, yet where the growth turned out to be of syphilitic origin. On the other hand, sarcoma may be confounded with phlegmonous swelling of the tonsil. Treatment can only be operative, either through the mouth, or by an external route in older cases. The prognosis is usually gloomy, as one would expect.—*Centralblatt fuer Chirurgie*, No. 8, 1902.—(From the promising reports of treatment resulting from the use of the X-rays in malignant growths, both internal and external, with a high-tension tube particularly, such cases should be given the benefit of the possibility of improvement, and even of cure. I once observed a case of carcinoma of the left tonsil in an elderly farmer. The tumor increased so much in size, and gave him so much distress and pain, that after having wandered about from surgeon to surgeon, in vain hope of relief, he, in a fit of despondency, jumped into Lake Erie from the deck of a steamer, and ended his misery.)

Frank H. Pritchard, M.D.

THE DIAGNOSIS OF TUBERCULAR PERITONITIS ON A BASE OF FIFTY-FOUR CASES.—Dr. A. A. Kissel, of Moscow, from an experience of fifty-four cases of this disease which he observed at the St. Olga Hospital, in Moscow, Russia, asserts this disease to be less rare than one would suppose. As diagnostic points, he points out:

1. Thickening of the peritoneum, which is tense, tender to pressure, while in the later stages one may detect hard and circumscribed infiltrations. He has been able to make this out in all cases where the two peritoneal layers were not grown together. In thirty-four cases where laparotomy was done, this membrane was found to be much thicker than was suspected. He lays a great deal of stress on this sign.

2. The simultaneous appearance of tuberculosis in other parts, especially in the pleura.

3. Enlargement of the superficial lymph-glands. A micropolyadenitis is particularly noticeable in tubercular peritonitis, for the lymph-glands of the axilla and neck may easily be felt through the thin and emaciated skin.

4. The exudate is very rich in albumin, and of a high specific gravity (as distinguished from that of peritoneal cancer, where it is of low specific gravity).

5. Tubercular peritonitis seldom begins with acute symptoms.

6. Very rapidly developing anæmia and emaciation in many cases are the first signs observed: for example, one child who, two months previously, had been in robust health, had greatly fallen away without taking to his bed. Examination revealed a pleuritis and a solid exudate below the umbilicus; laparotomy discovered great extensive adhesions of the intestines, and great masses of tubercles.

Among those conditions which may be confounded with this disease is chronic serous peritonitis, which, however, is of tuberculous origin, though at the time it may not be detectable. He refers to several such cases which were discharged seemingly cured, but who later developed the tubercular form of the disease.

Finally, an increase in size of the abdomen in rachitis may present a similar symptom-picture. In many cases a differentiation may be difficult, yet by careful examination it will be noticed that the abdomen in rickets is not indurated nor thickened, is round and tympanic in all its parts, with neither fluid nor hard plaques in it, and, finally, that there are no rachitic changes in the bones. The abdomen, on inquiring, will be found to have been enlarged for some time without any suddenly developing anæmia and emaciation. It is often difficult to prove the presence of fluid in the abdominal cavity, and, contrary to Hænoch's view, he has observed the disease not to be so very rare in young children; he has noticed three such cases under one year of age. Of these fifty-four cases, thirty-five were operated on, and of these, twenty-seven recovered and were restored to health. The exudate is not infrequently absorbed spontaneously during tonic treatment.—*Hospitalstidende*, No. 10, 1902.

Frank H. Pritchard, M.D.

BLUE PYOCTANIN IN ASCITES OF CARDIAC AND RENAL ORIGIN.—Dr. E. Loustverk, a Russian physician, in ascites of renal and cardiac origin has found that blue-pyocetanin, in a daily dose of .03, in three doses, exerts a favorable effect. In twelve cases treated thus, two gave up treatment on account of the nausea which it produced. In the other nine, where the usual diuretics, as digitalis, strophanthus, etc., had been tried and had failed, a decided amelioration was noticed after a few days, followed by a disappearance of the œdema and the dyspnœa, and by a decrease of the abnormal heart-sounds. It seems to act by increasing the quantity of urine and perspiration. In order to avoid nausea one should not administer it until three hours after meals.—*La Semaine Medicale*, No. 12, 1902.

Frank H. Pritchard, M.D.

ALBUMINOUS EXPECTORATION.—After reporting his case, and to some extent reviewing the literature, Riesman comes to the following conclusions:

(a) Albuminous expectoration is a very rare complication of thoracocentesis, and usually fatal.

(b) It consists in the expectoration of a viscid albuminous fluid, closely resembling the fluid of serous effusion.

(c) The condition is best explained on the basis of an intense congestion and œdema of the lungs.

(d) The principal causes seem to be a too rapid or too great a withdrawal of the fluid.

(e) Serious cardiac disease and morbid conditions of the opposite lung, hindering expansion, are predisposing conditions.

(f) Under all circumstances, but particularly when these complications exist, aspiration should be performed slowly. If the effusion be large, the amount withdrawn at one sitting should be small.

(g) In some cases it is better to repeat the operation in several sittings.—*The American Journal of the Medical Sciences*, April, 1902.

William F. Baker, A.M., M.D.

DIAGNOSIS AND TREATMENT OF LARYNGEAL TUBERCULOSIS.—(Donellen.)—The disease is usually secondary to an infection in the lungs. There are, no doubt, cases of primary infection in the larynx. The general symptoms complained of are loss of weight, general malaise, progressive weakness, cough, night sweats and expectoration. There is also noticed in the throat a sense of dryness, followed later by difficulty in swallowing. The dysphagia in the advanced cases is, perhaps, the most distressing symptom, for the patient is unable to take even the simpler foods. Impairment of the voice is soon observed, varying from a slight hoarseness to a complete aphonia. The cough is strident or brassy in character. With the cough there is expectoration, which is at first mucoid, but later becomes purulent, and may be mixed with blood, particularly after a severe spell of coughing. The daily evening exacerbation of the temperature and increase in the pulse and respiration are to be found at this period in the disease.

Examination of the sputum shows the presence of the tubercle bacilli. Laryngoscopic examination shows at first a diffuse hyperemia of the larynx, succeeded by infiltration of the mucous membrane, beginning usually in the inter-arytenoid space, or arytenoid cartilage, or on the laryngeal face of the epiglottis, or in the cords. The infiltration is usually unilateral. After a period of time the infiltration may so increase, and epiglottis become so œdematous, that the crescentic edge of the epiglottis may appear as a sausage-shaped tumor. Another group of cases shows a tendency to ulceration. The typical ulcers are shallow, irregularly circular, and are covered with a secretion that contains the bacilli.

Differential Diagnosis.—In syphilis the history will be of value, and other symptoms of the throat, nose and skin, the absence of pain, rapidly destructive character of the lesion, and the relief from antisyphilitic measures. In carcinoma, the severe pain, the presence of a rapidly growing tumor, the cachexia. In lupus the pain is not severe, there is less œdema, ulcers are infrequent, no tubercle bacilli, and the tendency of lupus to attack the cutaneous surface.

Treatment.—The best climatic and hygienic care. As to the local treatment, it is said to give very good results. The larynx is sprayed with a 10 per cent. sol. of cocaine. The parts are first cleansed with Dobell's solution, after with hydrogen peroxide, and then thoroughly rubbed with a 20 to 80 per cent. solution of lactic acid. This is repeated every third or fourth day. Orthoform, as a powder, will relieve the dysphagia. Other dusting powders, as aristol, acetanalid, iodoform combined with cocaine, have been of especial value. Early tracheotomy in impending suffocation.—*Medicine*, March, 1902.

William F. Baker, A.M., M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY O. S. HAINES, M.D.,

with the collaboration in German literature of C. Sigmund Raue, M.D.

ON PAYING MORE ATTENTION TO HOMŒOPATHIC THERAPEUTICS IN OUR MEDICAL SOCIETIES.—We notice that the Homœopathic Medical Society of the County of New York proposes to devote a portion of each of its monthly meeting to the discussion of homœopathic therapeutics. This is a move in the right direction, and one that might be followed with advantage by other societies. A similar plan has been followed during the past year in the monthly meetings of the A. R. Thomas Medical Club of this city. Two papers are presented at each meeting, one of which *must* always be upon the applied therapeutics of a homœopathic remedy. The success of this plan is already assured. A great many societies underestimate the interest which the majority of their members have in homœopathy and homœopathic therapeutics. To draw a crowd of homœopaths together, offer them a series of good papers upon applied homœopathic therapeutics. It's worth trying. The novelty of the plan would, in itself, be attractive.

PHYSOSTIGMA (CALABAR BEAN).—One may find many homœopathic suggestions and deductions in the current literature of the allopathic and eclectic schools, which only goes to prove that it's difficult to down truth. That interesting writer, "W. E. B.," has something to say about physostigma in the February *Eclectic Medical Journal* which is apropos. This drug is the favorite ordeal poison of some African tribes. Occasionally the condemned man survives. Innocence is not as strong a factor in their survival as violent emesis. The after symptoms are, however, severe. Extreme muscular weakness, slow, weak pulse, giddiness, vomiting and violent purging. Death occurs in less fortunate individuals from cardiac syncope, heart failure and paralysis of the respiratory centres. Now, continues the writer, the special indications for the administration of physostigma as a medicine are: Mental torpor, coldness of the surface of the body, a small, tense, rapid pulse; difficult breathing, and a sense of constriction about the chest. Such symptoms are seen in many nervous diseases. They are frequently the disease expressions in the impotent masturbator—the fellow who has unsatisfactory erections and a premature seminal discharge. In traumatic tetanus, in epilepsy or in cholera; with the above conditions prominent, this remedy should prove curative. The writer thinks that the remedy is worthy a trial in progressive muscular paralysis and atrophy; in cerebro-spinal meningitis, when there is dulness, torpor, and a very weak pulse. He also suggests its

use in locomotor ataxia, paraplegic myelitis, writer's cramp, and in trismus neonatorum. This remedy is frequently suited to the symptoms which are incident to the change of life in women.

CACTUS GRANDIFLORUS.—Apropos of somebody's advice, published in "American Medicine," to the effect that we must administer this remedy in doses of from ten to forty drops of a fluid extract, Dr. J. R. Green, of Chicago, says that, as a result of many years' experience, he has found the fluid extracts of cactus substantially useless. An alcoholic tincture of the *fresh* plant is more certain and more active. The dose of the alcoholic tincture should not exceed one drop, and better results may often be obtained from one-fifth of a drop. Doses of more than one drop are certain to aggravate the symptoms for which it has been prescribed.—*Pacific Coast Journal*.

SIGNIFICANCE OF ABDOMINAL PAIN.—One thing that I have learned from experience is that abdominal pains are much given to wandering about before they finally settle down to business at the actual seat of trouble. As a consequence ; snap judgment, in the early stages of an attack of abdominal pain, is often a bad guess.—Lincoln Philips, M.D., in *Med. Century*.

A SUCCESSFUL TREATMENT FOR OVARITIS.—Dr. Frederick Kopp, of Greenwich, N. S. W., considers ovaritis a common affliction among Australian women. He has treated a number of cases of this disease successfully, and recommends colocynth internally, and the iodide of potash liniment externally, as remedies *par excellence*. The following case is mentioned, as it seems to illustrate well the kind of case for which Dr. Kopp recommends these remedies. In reporting favorably regarding any drug or method of treatment, the writer should always be careful to state *when* the remedy is to be administered, and *how*. The patient was a married woman, who had several children. She had also had two miscarriages. Her pain was burning and shooting in character, agonizing in intensity. It extended from the left ovary, down the thigh to the left knee. Colocynthis tincture was administered in two minim doses, every three hours. Externally, the iodide of potash liniment was well rubbed in over the affected ovarian region, twice daily. In three weeks all signs of disease had disappeared. This is a typical case for the treatment, says Dr. Kopp. The author does not specify the strength of the liniment used. In one respect this case is odd ; inasmuch as the woman could take two minims of colocynth tincture every three hours, for a period of three weeks, without experiencing untoward effects. Indeed, we can but doubt that she did take the remedy as steadily as that. The report, however, makes it appear that she did.—*Homœopathic World*, March, 1902.

ACTEA RACEMOSA.—"Facial blemishes in young women" may be considered one of the most important indications for actea. The pimply eruptions and the rough skin, nearly always aggravated at the menstrual periods. The menses are irregular as to time of appearance and amount, with a tendency towards profuse flowing. If such an actea patient has just passed puberty ; she will be observed to have a dirty, blotched-looking skin, with small elevations that, at first, seem as if they might suppurate. They do not, however, but turn brown, and then are slowly absorbed. At each returning menstruation, before passing away, these blotched eruptions show slightly elevated and red again. Every physician is aware of the influence of the menstrual cycle upon

the unsightly eruptions which mar the faces of young ladies; especially about the forehead, wings of nose, angles of mouth and the chin, and we have all, doubtless, wished many times for a specific remedy for such troublesome affections. Dr. E. Stillman Bailey has had some excellent results in the treatment of this class of cases, by carefully noting the accompanying nervous symptoms. Young women, and especially neurotic subjects, seem to be the ones most afflicted. They try, one after another, the salves and lotions of the public press, then they follow religiously the advice of doctors as to diet, rest and bathing; but they do not get well. Such cases are so anxious to get well that they create a form of nervous unrest that ripens into an apprehension that they are incurable. They become hysterical, gloomy, despondent, morbid and retiring. They imagine that their friends notice and make comments upon their unsightly appearance. In the *actea racemosa*, says Dr. Bailey, we have a remedy which will often correct these nervous symptoms. Moreover, as its greatest sphere of action is upon the generative tract, it will also relieve the pains in the back and across the thighs, and the bearing-down sensations which are so often present in such cases. It relieves the irritation of the sympathetic nerves, and in this way the vaso-motors of the capillaries are influenced; and the facial eruptions either do not appear, or are improved or cured. We look upon this note of Dr. Bailey's, upon the influence of *actea* in this class of cases, as quite valuable. It is to be hoped that other physicians may be able to confirm his recommendations. *Actea* is also one of our best backache remedies, and it influences very favorably the infra-mammary pains so frequently associated with ovarian irritation upon the same side. The author prefers to use *actea* in low potencies, and to repeat the doses at frequent and regular intervals.—*The Clinique*.

AN ECLECTIC VIEW OF THE TREATMENT OF GONORRHOEA. — Dr. W. C. Cooper, apparently, has not been deeply impressed with the efficacy of the germicidal treatment of gonorrhœa. Dr. Cooper is the man who writes those insomniferous editorials in the *Medical Gleaner*; it being impossible for one to go to sleep while he is reading Dr. C.'s inspirations. The author believes that oil of sandalwood is the best single remedy for ordinary cases of the disease under consideration. During the very acute stage, he uses a combination of specific tinctures of aconite and gelsemium. While the patient is taking this combination internally, he also advises to inject, three times each day, some of the following solution: Distilled hamamelis, Lloyd's hydrastis, of each one ounce; water, two ounces. He lays great stress upon the importance of distending the urethra with urine every time patient urinates. This is accomplished by momentarily closing the meatus with thumb and finger, filling the urethra to its utmost capacity and suddenly letting go. After this procedure, the injection is to be taken in the ordinary way. After the acute stage has passed, two grains of sulphate of zinc may be added to each ounce of the mixture, and the aconite and gelsemium are replaced by the oil of sandalwood. Here, again, Dr. Cooper finds it necessary to mix his oil of sandalwood—with tincture of staphysagria. He makes an essence of the oil before mixing. Quick cures are promised from this treatment. It is a pity that remedies whose indications are as clear-cut as those of aconite and gelsemium, cannot be used singly and alone. Nothing is gained by the combination, if we know exactly the circumstances and conditions under which each

will exert its full therapeutic effects. Homœopathy teaches this. In concluding his article, Dr. Cooper says he has been impressed with the fact that gonorrhœa and honesty are incompatible. No victim of this disease will pay his doctor if he can help it. We have found that they pay very promptly—if you make them.

CHIONANTHUS IN THE TREATMENT OF DIABETES MELLITUS.—“I can conscientiously say that I have never treated a case of diabetes mellitus, along the lines herein indicated, that has not yielded to the treatment; to the satisfaction of myself and patient.” This is a very positive statement from the pen of Dr. A. P. Hauss, who gives his experience with diabetes in last month's *Eclectic Medical Journal*. The true student of therapeutics can hardly afford to ignore any therapeutic announcement that is based upon painstaking and thorough investigation, even though the methods of investigation, by which that knowledge was obtained, do not agree with his own methods exactly. The specific indications upon which the eclectic physicians prescribe are, we presume, the results of bedside experience. As the author remarks, diabetes has its full share of reputed remedies, most of which are harmful, much less useful. The indications upon which we would select the chionanthus for a remedy are these: The patient has a functional disorder of the liver; intense thirst, specific gravity of the urine from 1030 to 1040, frequent and copious urination, more or less nervous prostration, loss of weight, and night-sweats. In the largest proportion of such cases there is constipation, the stools being white and devoid of bile. During his twenty-one years of practice the author has prescribed this remedy, his experience with it being embodied in the remarks with which this article opens. Ten to fifteen drops of the chionanthus tincture is advised, four times daily. In addition to this remedy, Dr. Hauss does not neglect the dietetic nor the hygienic part of the treatment. He also believes that the intestinal canal should be flushed each morning, one hour before breakfast; by drinking one or two pints of hot water, in which are dissolved one-half to one teaspoonful of sulphate of magnesia, or one-half to one wineglass of French Lick Pluto Water. He continues this line of treatment until the specific gravity of the urine is normal. The *Chionanthus Virginica* has been proven, and has been successfully used by our school in hypertrophy of the liver, malarial affections, jaundice and gall-stone colics. So far as we know, it has not been found useful in diabetes mellitus. It is comparatively easy to confirm or disprove its usefulness here, and we should do so. Most physicians will be glad to welcome it as an addition to their effective medicaments in diabetes,—if they can confirm Dr. Hauss's results.

A CALCAREA CARB. POINTER IN INTERMITTENT FEVER.—Dr. A. W. K. Choudhury, of Satkhira, India, claims that if we study our cases of intermittent malarial fevers properly, and if we select the right remedy, there is scarcely any fear of being unsuccessful, and success is often apparent after the first dose of medicine. We must remember that Dr. Choudhury knows what he is talking about. His experience in the treatment of malarial fevers must have been a large one; much larger, indeed, than the experiences of some of us who will be inclined to question the efficacy of the potentized remedy in these troublesome malarial affections. His conclusions are, therefore, worthy of the most careful investigation. He says, further, it is proper

to give but one dose of the remedy during the apyrexia, and, preferably, a little before the termination of the apyrexia. The author does not ask us to believe his statements without proof. He relates cases which clearly show such a plan of medication to be efficacious and curative. A valuable indication is mentioned under *calcarea carb.* "The time of accession of fever is, one day, at eleven in the morning; and the next day, at four in the afternoon."

These two paroxysms are not alike. The one at eleven in the morning is the severer; the four o'clock paroxysm is milder. The four o'clock paroxysm may be an incomplete one. It is a tedious and difficult task to study a case of intermittent fever "properly," and to select the curative homœopathic remedy. Dr. H. C. Allen has done more than any other one man to lessen the difficulties of such a task. His new book, "The Therapeutics of Fevers," is, in our estimation, one of the most valuable works in homœopathic literature.—*Hom. Recorder*, April 15, 1902.

MEDICINAL TREATMENT OF PULMONARY EMPHYSEMA.—Dr. C. Gatchell praises the action of the following remedies in this troublesome affection. We are waiting, by the way, for the appearance of Dr. Gatchell's new work upon "Diseases of the Chest." It will doubtless be a welcome addition to the library of every physician, because it will embody the results of the author's ripe experience. Too many books are written, nowadays, from the "they say" standpoint. What we need are a few from the "I know" point of view.

Antimonium Ars. 2x.—Useful in the advanced stages of emphysema, with excessive dyspnœa, severe paroxysmal cough, and asthmatic attacks. It also relieves the accompanying dyspeptic symptoms, when this condition is prominent.

Calcarea Carb. 6x.—Emphysema in fat subjects; chronic bronchitis is prominent, much perspiration, and profuse menstruation in the females.

Calcarea phos. 2x, on the other hand, suits subjects of arterio-sclerosis, in advanced life.

Phosphorus 2x suits subjects in which there is fatty degeneration of tissues.

Aurum muriaticum 3x suits nervous subjects, with urine of low specific gravity and sclerosed arteries.

Glonoin 2x is useful during asthmatic attacks, when the arterial tension is high.

In the later stages of emphysema, the weak heart often demands stimulant treatment. The author recommends for use, here, strychnin. 2x, spartein sulph. 1x, agaricin 1x.—*Medical Era*.

TUBERCULINUM.—It may possibly be of interest to some to know that in several cases of adenitis, after operation for removal of the diseased glands, this remedy seemed to cause the absorption of the remaining enlargements. In one case the scar-tissue was considerable, red and angry looking for some time. The neighboring glands became enlarged after operation, and were painful. Tuberculinum 200, occasionally given, seemed to assist in the disappearance of these glands. We are unable to give precise indications, save that the remedy was prescribed on account of the tubercular family history, and for the recurring glandular enlargements, after operation upon the neigh-

boring glandular structures. This experience is trifling, yet the results are more or less suggestive. In a later case of similar character the results have not been so promptly manifested. She is still under observation.

DISINFECTION OF DWELLINGS.—Dr. Q. O. Sutherland thinks that all contagious diseases are kept alive by lack of *proper* disinfection of dwellings and wearing apparel. This applies particularly to the country districts, in which, very often, the family must do its own fumigating. It would certainly be practicable, we think, for the private family to properly disinfect its own household nowadays. Suitable formaldehyde generators can be purchased so cheaply, and the method is so simple, that, in the absence of a public fumigator, the family physician should see that disinfection is thoroughly performed.—*The Medical Magazine*.

ARSENITE OF COPPER IN RENAL INSUFFICIENCY.—G. M. Hill, M.D., says that this remedy would certainly be his first choice in any one of the various forms of chronic renal disease accompanied by a reduction in the output of urea. He mentions the case of a woman, aged forty-two years, who had an obstructive murmur at the pulmonary valve, and who suddenly collapsed after an over-exertion. He made a diagnosis of acute cardiac dilatation; and, for weeks, the patient was very ill. After her heart had been in a measure restored to a safe condition by rest and medicines, attention was directed especially to her kidneys, which, from the first, had showed signs of passive congestion. Albumin was present, but no tube-casts. Diuretics increased the *amount* of urine excreted, but did not materially increase the amount of urea. Under the influence of one-grain doses of the 2x trituration of arsenite of copper; the urea has increased from six or eight grammes daily, to twenty-six grammes daily at the last examination.—*The Clinique*.

THE FUNCTION OF MEDICINE.—Dr. W. J. Hawkes, of Los Angeles, in the March number of the *Pacific Coast Journal*, brings up anew the question, "What, in a therapeutic sense, is the function of medicine?" There can be no doubt but that an incorrect understanding of this question is more or less responsible for the large and increasing doses of crude drugs, in the belief that it is the drug, *per se*, that does the healing. It may also be the cause of such a widespread adherence to the "building up" process by drug "tonics." And we have no doubt that, if physicians understood this matter better, they would not continue to give the drug so frequently after their patient is well on his way towards recovery. Dr. Hawkes thinks that the true and only function of medicine is to enable nature to do her best. Medicine does not supply nutrient material to repair waste in the invalid; it cannot take the place of nature nor supply new vitality. It simply, in some way unknown to us, corrects the derangements of the vital forces, sets nature on her feet, as it were, and she herself does the repairing and cleansing of the diseased and impure body. A correct understanding of the function of medicine explains the philosophy of discontinuing the administration of medicine after we have seen evidences of improvement in the patient. "When a shock of some kind has deranged the integrity and function of the nerve-centre or ganglion governing an organ, the result is deranged function or disease." The appropriate medicine makes such an impression upon the deranged centre as to restore its integrity and function; and nature removes, as far as is possible,

the visible results of diseased action. The author is of the opinion that when unmistakable signs of improvement follow the administration of a remedy, it is often positively *harmful* to continue that medicine in frequent dosage.

BARYTA MURIATICUM.—Barium and its salts, says Dr. Stonham, are well known to exercise a marked effect upon the unstriped muscular coats of the arteries, stimulating them to contract, and probably also influencing their nutrition. This may be the reason why barium has been used in the treatment of *aneurysm*. There are several successful cases reported in our literature. Dr. Stonham adds several other cases; which, while they could hardly be called cases of true aneurysm, upon the data given, show that there was a localized lack of tone in the muscular arterial coats, some dilatation, throbbing and pain. It is not unreasonable in the author to conclude that such cases might ultimately proceed to aneurysmal dilatation. At all events, the effects of the administration of baryta mur. were very happy. It is not often that cases of this nature are reported. A middle-aged woman complained of pain in the left shoulder, worse on movement. On examination there was found, above the left clavicle, swelling and increased pulsation. Apparently this was due to a dilated condition of the subclavian artery. Beneath the clavicle, over the outer part of the first intercostal space, pulsation could also be felt. The pain extended down the left arm. She suffered from flushing of the face. The author does not tell us about the condition of her heart, so it is presumed that organ was in a healthy state. The remedy chosen was baryta mur. 3. Later on the 1x was used for a short period. Duration of treatment was one year. Medicine was given interruptedly. Result, recovery and disappearance of above physical signs.

A woman aged 38 years had for three years suffered from pain in left chest and left arm. There was a bulging at the junction of third rib with its costal cartilage. This had been diagnosed aneurysm by another observer. We are told that a systolic murmur could be heard over this bulging, transmitted to the left and under clavicle. No impulse could be felt, however. No other heart murmur was present, but the apex was in the nipple line. The sphygmogram showed a rapid pulse of low tension. This patient lifted and carried heavy articles with her left hand. She had much pain running down that arm to the elbow and stinging pain under the left clavicle. She also suffered from rushes of blood to the head, faint feelings, and dyspnoea on exertion. The remedy chosen for her was baryta mur. 1x. All symptoms disappeared, save slight bulging at the location first mentioned.

The author then refers to a series of cases in which there were sharp abdominal pains between the navel and the ribs on the left side, worse from any exertion. Pains centering about the umbilicus, with sinking feeling—worse likewise from motion. All these cases had associated with their abdominal pains undue aortic pulsation. Baryta mur. 3x was successful in these cases, as in the former ones.—*Monthly Hom. Review*.

LILIUM TIGRINUM.—Dr. Bailey has been in the habit of using this remedy when a patient flinches when deep pressure is made over the ovarian region. The first pain experienced, after this pressure, is sharp in character. This is followed by a duller pain. Such symptoms are usually of a chronic nature, and the women are apt to become very apprehensive of injury to the ovaries.

They fear, and cannot bear, light touch, or the pressure of clothing or bedding. This apprehension is one of the finer distinctions in affiliating the remedy.—*The Clinique*.

ARSENICUM IODATUM.—In the *Medical Magazine* for March 15th, Dr. J. G. Randall considers at length the remedies which he has found efficacious in the treatment of eczema. He selects his remedies for this affection according to their well-known indications, and prefers the higher potencies, as a rule, for the very excellent reason that these preparations act promptly and positively. He refers to one case, which was quickly relieved and cured by arsenicum iodatum, 3d potency, after other remedies had failed. Some may doubt that this case was eczema; but the doctor does not say what his diagnosis was in this case. He simply mentions it, in the paper, under title of eczema. The patient had many *vesicles* upon the backs of his hands, and along the sides and backs of the fingers. The eruption *itched* and *burned* to such a degree that the man was almost beside himself. Within twenty-four hours these vesicles would break, leaving red spots, which exuded a sanious secretion. The burning and itching continued, and was worse after scratching. There was a nightly aggravation from twelve until two o'clock. The same eruption next appeared upon the face, the skin being red and burning. Among the remedies which failed to relieve were arsenicum album 3d and 30th. The improvement began after twenty-four hours' use of the iodide of arsenic.

HICCOUGH.—A very clever article upon this subject may be found in *Medical Era* for April. Dr. W. J. Anderson is the author, and it is part of a communication on the action of strychnine, read before the Homœopathic Medical Society of Chicago. Every case of hiccough is due to a clonic contraction of the diaphragm. A clonic contraction of a muscle is an abnormal contraction, and is always a symptom of irritation. Hiccough is due to some irritation of the phrenic neurone. It may be produced by an abnormal metabolism within the cell-body, as the uræmic, the hysteric, and the hiccough which occurs after severe hæmorrhages. The irritation may occur either along the course of the axones, as the hiccough of mediastinal tumors or of aneurysm; or it may affect, directly, the cell-bodies in the anterior horn of the cervical spinal cord; as when an acute poliomyelitis involves the phrenic. From the fact that the phrenic is in close approximation to the vagus and other cranial nerves, a hiccough may be produced as the result of some primary sensory condition, and give rise to the so-called reflex hiccough. Thus we may explain the hiccough of the new-born babe, the inveterate user of tobacco, the dyspeptic, etc. When hiccough is of reflex origin, and we can diagnose the source of the irritation, it is comparatively easy to relieve such a case. But when the cause is a direct irritation of the phrenic neurone, as in uræmia and hysteria, and after severe hæmorrhage, the cure is more difficult. The author narrates some interesting cases of this nature, in which such remedial agents as morphia, atropin, pilocarpin and faradism failed to cure. In these cases, strychnin. sulph. acted very satisfactorily. It was sometimes used hypodermatically; and, again, in the second decimal, by the mouth. It is a well-known fact that strychnine produces clonic contractions of muscles. It probably acts directly upon the internal morphology of the motor neurone. It is not unreasonable, then, to claim that its curative action in these cases was due entirely to its homœopathicity.

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A Medical Newspaper.

EDITED BY
HERBERT P. LEOPOLD, M.D.

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Diseases and Therapeutics of the Skin. By J. Henry Allen, M.D., Professor of Skin and Venereal Diseases, Hering Medical College, Chicago, Ill. Philadelphia: Boerick and Tafel. 1902. Price, \$2.00 net; by mail, \$2.12.

The author in this little work has presented a concise and clear manual for the benefit of the student and general practitioner. The history, pathology and pathological anatomy of the various skin diseases have been dealt with briefly, partially owing to the present uncertain knowledge on these subjects, and partially owing to the differences of opinion held by the homœopathic physicians and our colleagues of the allopathic school. The author has also endeavored to make the therapeutic part as strong as possible, though limited by lack of space in a work the size of the one before us. He expresses a hope

later on to supplement this work by a repertory wholly confined to the symptoms relating to the skin.

The International Medical Annual: A Year-Book of Treatment and Practitioner's Index. 1902. Twentieth Year. New York: E. B. Treat & Co. Price, \$3.00.

This small annual—small comparatively speaking, for it contains 700 pages—is now the oldest work of its class in the English language. This of itself testifies to its worth. The matter presented renders it possible for all practitioners to keep themselves abreast of the times. No effort on the part of the editors and publishers has been spared to make the work worthy of the acceptance of the medical profession. Due effort is made to present conflicting views with impartiality, thus leaving the reader to form his own opinions.

The Diagnosis of Surgical Diseases. By Dr. E. Albert, late Director of the First Surgical Clinic at the University of Vienna. Authorized translation from the eighth enlarged and revised edition. By Robert T. Frank, A.M., M.D. With 53 illustrations. New York: D. Appleton & Co. 1902. Price, \$5.00.

This volume presents to the practitioner and to the student the problems in diagnosis which confront them at the bedside. In order to achieve this object, theoretical classifications are not adhered to; instead, diseases are grouped according to their point of general resemblance—considerations which in practice render their differentiation difficult. In this way the advantages of clinical teaching are most nearly attained, and by the presentation of a large number of cases the value of this arrangement is further enhanced. The fragmentary and disjointed instruction which clinical demonstration necessarily entails, even under the most favorable circumstances, is thus systematized. Moreover, whenever feasible, the cases reported are followed to the operating table, at times to autopsy, either to confirm or to correct the diagnosis. In marked contrast to the numerous works on medical diagnosis now accessible to the American reader, works on surgical diagnosis are comparatively few.

A Dictionary of Practical Materia Medica. By John Henry Clarke, M.D. The Homœopathic Publishing Co., London. 1902. Volume II., in Two Parts.

The completion of Dr. Clarke's "Dictionary of Materia Medica" is, we think, an event in homœopathic literature. Since the appearance of Volume I. of this work, we have had opportunities to become well acquainted with its particular merits; and the book grows upon one. While the dictionary is doubtless an excellent volume from which, with the aid of a repertory, to individualize the remedy, we still think its chief practicality and charm lies in the fact that it is a *materia medica* that can be studied, and studied with pleasure as well as profit, because of the entertaining style in which it has been written. This feature should commend it to medical students, to whom often our *materia medica* appears as more or less of a bugaboo. The sincerity of the author is unmistakable. He is an enthusiastic homœopath, and his enthusiasm proves contagious before the reader has gone far into the book. Some idea of the magnitude of Dr. Clarke's undertaking may be gleaned from the fact that, when completed, his dictionary will contain about 2570 pages, in which some thousand different drugs have been considered. The author and his publishers very wisely concluded to bind the second volume in two parts, which they have, however, paged throughout as one. Otherwise, the reader would have had to nurse a volume of 1613 pages. In a prefatory note to volume second we are promised a "Clinical Repertory and Concordium," which will appear as a companion to the dictionary. This should much enhance the value of the latter.

Manual of Childbed Nursing, with Notes on Infant Feeding. By Chas. Jewett, A.M., M.D., Sc.D., Professor of Obstetrics and Diseases of Women in the Long Island College Hospital. Fifth edition, revised and enlarged. New York: E. B. Treat & Co. 1902. Price, 80 cents net.

This nursing manual was first prepared for the instruction of the nurses in the training-school at the Long Island Hospital. Subsequently it was re-written and adapted to general use. In this edition the entire contents have been revised and much new matter added. The object has not been to furnish a text-book, but rather to aid the nurse in remembering the more important teachings of hospital training. The book in its present form will be found of service not only to professional nurses, but to mothers as well, and to all interested in obstetrics.

A Timely Treatise on Small-Pox, to sell at \$3.00, is announced for publication early in May by J. B. Lippincott Company. It is written by Dr. George Henry Fox, Professor of Dermatology in the College of Physicians and Surgeons, New York City, with the collaboration of Drs. S. Dana Hubbard, Sigmund Pollitzer and John H. Huddleston, all of whom are officials of the Health Department of New York City, and have had unusual opportunities for the study and treatment of this disease during the present epidemic.

The work is to be in atlas form, similar to Fox's "Photographic Atlas of Skin Diseases," published by the same house. A strong feature of the work will be its illustrations, reproduced from recent photographs, the major portion of which will be so colored as to give a very faithful representation of typical cases of variola in the successive stages of the disease, also unusual phases of Variola, Vaccinia, Varicella, and diseases with which small-pox is liable to be confounded. These illustrations number thirty-seven, and will be grouped into ten colored plates, $9\frac{1}{2} \times 10\frac{1}{4}$ inches, and six black and white photographic plates.

The names of Dr. Fox and his associates assure the excellence of the work, in which will be described the symptoms, course of the disease, characteristic points of diagnosis, and most approved methods of treatment.

New York News Letter.—The regular meeting of the Academy of Pathological Science was held on Friday evening, March 28th, at the residence of Dr. W. H. Bishop, 56 West Forty-eighth Street. Several candidates were nominated for membership. The following subjects were presented and discussed: "Treatment of Lateral Spinal Curvature by Medical Gymnastics," by Dr. Hugh Kidder, who illustrated his methods with two patients. "Halstead's Operation for Removal of the Breast" (specimen), Dr. Wm. H. Bishop; discussed by Drs. Doughty, Tuttle, Van Denburg and others. "Report of a Case of Diabetic Urine of Low Specific Gravity," by Dr. H. G. Keith; discussed by Drs. Laidlaw, Van Denburg and Rudderow. Dr. G. F. Laidlaw showed the following specimens, with histories: Malignant tumor of bladder, with metastatic growths; horseshoe kidney; recent hydronephroses, three cases; tubercular ulcers of intestine; calcified pleura costalis in case of phthisis; Dr. S. F. Wilcox, lympho-sarcoma of breast.

The New York County Homœopathic Society held its regular meeting Thursday evening, April 10th. Five candidates for membership were elected, and twenty-five candidates were elected to corresponding membership. This was announced as a materia medica meeting, and Dr. E. B. Nash, of Cortland, N. Y., presented a paper entitled "Materia Medica and Therapeutics: Proper Selection of the Homœopathic Remedy." A very interesting discussion followed. Among those taking part were: Drs. Edmund Carleton, C. C. Howard, W. I. Pierce, Milton Powel, St. Clair Smith, C. W. Butler, Samuel D.

Long, Edward Rushmore, Wm. S. Searle, Thomas Dillingham, L. de V. Wilder, and Dr. A. B. Norton, who made the motion that a vote of thanks be extended to Dr. Nash for his address, which had occasioned such an interesting meeting. the attendance being the largest of the year. The committee on pathology presented a paper, "Etiology and Pathology of Lymphoid Hyper-trophies," by Dr. Irving Townsend; discussed by Drs. Vehslage and Garrison.

Metropolitan Hospital: Recent appointments on the Auxiliary Board are: Dr. M. R. Bren, Obstetrical Division; Dr. H. S. Hathaway and Dr. B. D. Walker, Visiting Physicians.

Died.—Dr. William Gottschalk, of Central Falls, R. I., died April 3, 1902. Bright's disease.

William von Gottschalk was born in New York forty-seven years ago, and when a mere lad went to Providence with his parents, his father being the late Dr. William von Gottschalk. He obtained his early education in the Providence public schools and in the Boston University School of Medicine, from which he was graduated in 1877, with the degree of M.D. He practiced his profession for a short time in Providence, and in 1877 removed to Central Falls, where he had resided since, having built up a large and lucrative practice at his profession. He was a staunch Democrat in politics, and for many years had taken an active interest in political matters. Before the division of the town of Lincoln he was elected a member of the lower branch of the General Assembly, and served as Representative in 1888, 1889 and 1890. He was elected Mayor in 1895.

Removals.—Dr. J. T. O'Connor has removed his office from 24 W. 45th Street to 7 West 42d Street, New York City.

Dr. Wm. Tod Helmuth has removed to 667 Madison Avenue, New York City.

Dr. John A. Evans has removed to 22 N. Carey Street, Baltimore, Md.

The annual commencement exercises of the Detroit Homœopathic College was held in the Detroit Opera House April 22d, Detroit, Michigan.

American Institute of Homœopathy.

OFFICE OF THE SECRETARY,

100 STATE ST., CHICAGO, April 19, 1902.

To the Members of the Profession: Any member of the profession desiring to procure an application-blank for membership in the American Institute of Homœopathy will have one sent to him by return mail on receipt of a postal-card request. Blanks will be sent with the Annual Circular, but they can be procured in the above manner at any time.

Fraternally,

Ch. Gatchell.

Report of the Committee on Transportation, A. I. H.

The Committee on Transportation of the American Institute of Homœopathy is able to report that the various railroad associations throughout the country have agreed to make a rate of a fare and one-third for the round trip, on the usual certificate plan. This applies as well to the "allied societies" meeting at the same time,—Cleveland, O., June 17-21,—and arrangements have been made for the presence of a special agent of the railroad on Tuesday, Wednesday, Thursday and Friday, so that any member being unexpectedly called away during the meeting may have the benefit of the reduced fare, by having his ticket vised. A large attendance is confidently hoped for.

Fraternally yours,

J. B. Garrison, M.D.,

Chairman.

The Managers of Middletown, N. Y., Insane Hospital.—The Board of Managers of the Middletown State Hospital met March 20, 1902. It was the last meeting of the Board, the amendment to the insanity law passed by the Legislature having abolished boards of managers and created boards of visitation therefor.

There were present President U. T. Hayes and Messrs. W. Stansbury, J. B. Carson, J. W. Slauson, E. D. Tompkins and John D. Stivers, of Middletown, and Frederick W. Devoe, of New York City.

Dr. Talcott, the Superintendent of the hospital, read his quarterly report. In closing the report Dr. Talcott said :

"I wish to extend to all the members of the Board my most cordial thanks for the clear and plain directions given in the rules and regulations established by you for the guidance of the officers and workers at this hospital. I also wish to thank you for the unselfish aid, careful advice, constant encouragement and wise suggestions which you have always offered to the Superintendent and his co-workers during the past twenty-five years."

The following was read :

	Men.	Women.	Total.
Admitted since opening (April, 1874), . . .	3000	2982	5982
Discharged since " " . . .	2308	2317	4725
" recovered " " . . .	1032	1152	2194
" improved " " . . .	338	337	675
" unimproved " " . . .	324	381	705
" dead " " . . .	678	443	1121
Percentage of recoveries on whole number admitted, . . .			36.67
Percentage of recoveries on whole number discharged, . . .			46.45

The members then adjourned to the home of the Superintendent, where they were cordially received, and later sat down to dinner in the dining-room, which had been elaborately decorated with flowers for the occasion.

At the conclusion of the dinner President Hayes arose and presented Superintendent Talcott, on behalf of the retiring Board of Managers, a massive gold-lined loving cup, of handsome design.

The Homœopathic Medical Society of the County of Philadelphia.—A regular meeting of the Homœopathic Medical Society of the County of Philadelphia was held in the Alumni Hall of the Hahnemann Medical College March 14, 1902. At the completion of the business meeting the following paper, on "The Importance of a Careful Urinary Examination," was read by Dr. F. Mortimer Lawrence :

In these modern days, when no man can rightfully claim to be rated a competent physician unless a microscope is his constant companion, an exchange of opinions as to the importance of each phenomenon observed in the course of clinical examinations cannot fail to bring forth many details of vast importance.

The methods and technique of urinary examinations have been ably set before you. Let me now ask you, of what conditions, pathological or otherwise, does the urine afford evidence? Briefly stated, they are as follows :

1. *The progress of metabolism.* For example, the product of albuminoid disintegration in the human body is urea, and the latter is excreted in the urine. If we determine the amount of urea excreted during a period of 24 hours we can, knowing within what limits normal urea-excretion may vary, judge with fair certainty the relation of nitrogenous income to output. On the other hand, faulty metabolism of the carbohydrates may lead to the excessive accumulation of sugar in the system, and of this glycosuria is the signal.

2. *The condition of the urinary tract.* The appearance in the urine of albumin and of certain histological elements, such as renal epithelium, *débris* and

casts, is our one, single, positive sign of renal disease. Scarcely less important is the discovery of urinary decomposition induced by bladder disease.

3. *The condition of other organs.* We are too apt, in our search for evidence of kidney disease, to forget that the urine sometimes affords valuable evidence of disease elsewhere. Notably is this true in disease of the liver, when bile-stained urine may be the one symptom whereby we are enabled to distinguish jaundice from bronzing of the skin due, say, to Addison's disease.

Less often utilized, and yet possessing a "localizing" value almost like that of a signal symptom in convulsions, is the relationship of indican urea to disease of the small intestine.

Considering the wide range of this information, it is no wonder that no physician would attempt to treat any case in the slightest degree chronic without first examining the urine in its gross, its chemical, and its microscopical aspects. It would require a volume of no small size to properly catalogue the diagnostic and prognostic information which this procedure may afford, but it is my intention to run over very briefly, and chiefly as a basis for discussion, a few leading points.

And, first, as to the gross physical examination of a specimen of the urine. It is my impression that too many of us, in our haste to use the test-tube and the microscope, neglect to take advantage of this least technical of investigations. No urinalysis possesses great value unless it includes two items, viz., the total quantity and the specific quantity. The two are necessary corollaries, one to the other; for how different is the importance of a specific gravity of 1008 or 1010 in a patient of regular habits passing but little more than his normal 3 pints of urine, from the same specific gravity in, say, one of our beer-drinking German friends, who, as the result of excessive libations, has in the course of 24 hours poured forth 3 quarts or more!

In many cases the specific gravity affords a crucial test for diagnosis. For example, in more than one instance the discovery of a number of narrow hyaline casts has led to a diagnosis of nephritis, when the observer, had he but paid attention to the sp. gr. of 1020 or more, could scarcely doubt that he was dealing with a passive hyperæmia of the kidney, due, probably, to broken cardiac compensation. This is, as regards prognosis, often a matter of life and death; for appropriate treatment of the heart lesion usually removes completely the evidences of renal involvement, and gives the patient years of life.

Of the color, the reaction and the transparency of the urine I need say little. The brown urine with yellow from jaundice, the urine red with blood or black with its pigment, and the pale urine of interstitial nephritis, diabetes, hysteria, and simple polyuria, are well known to you all. So is the cloudiness in urine due to urates quickly dissipated by heat, which may suggest that we are dealing with the concentrated urine of a gouty subject; and the turbidity of alkaline urine which is so often due to phosphates, and is then dissipated by the addition of a few drops of acid.

But let us hurry on to our second examination, that by chemical means. Our practical routine includes but three tests: two simply qualitative and for abnormal constituents, albumin and sugar; and one quantitative, for a normal constituent, the urea.

When Bright discovered the relation of albuminuria to diseases of the kidney he did more than revolutionize our knowledge of those diseases, for he laid the foundation of our modern clinical laboratory methods in diagnosis. In one contention, however, I trust you will agree with me—that the absence of albumin affords no positive evidence of the absence of renal disease. In the vast majority of cases chronic interstitial nephritis is accompanied by little or no albuminuria, and woe be unto the physician who does not remember this, and thus fails to utilize the ureometer and the microscope to complete his investigation.

As to sugar, there is but one point of great importance, and this well known to you all—that glycosuria is no more a disease than is a cough. Too often we are inclined to say “diabetes” when, if we but glance at our stout, over-fed, middle-aged patient, we can, instead, assume that we have to deal with an alimentary glycosuria which, if we but limit his ingestion of carbo-hydrates and increase his physical exercise, will prove harmless and controllable. Diabetes, let us remember, is a generic term: it may be pancreatic and fatal, neurotic and serious, or dietetic and benign; and which of these it is we must determine by the age, physique and history of the patient.

Far more important, perhaps the most important, detail of the whole examination is the estimation of the total daily output of urea. This, the chief end product of albuminoid disintegration, by its amount, informs us accurately as to the extent to which the kidneys are performing their excretory functions. If we find that, instead of the 300 to 600 grains which are normally thrown off in 24 hours, the amount is persistently below 250 grains, the kidneys are almost certainly diseased. If, moreover, the amount falls below 175 grains daily, we can almost certainly foretell an uræmic attack. With such essential information to be gained, we are culpable if we fail to repeatedly estimate the urea in all our suspected urines.

Finally, as to the examination of the sediments. The man who has not used the microscope has not examined the urine. Important though the physical and chemical characteristics of the excretion, often essential though they are, in general their significance, either negative or positive, is vastly less than that of the sediments revealed by the microscope. Let this statement be understood as qualified, however; for the interpretation of those latter phenomena must always be qualified by the other finding.

It would be impossible for us to pass in review to-night all that may be seen in the urinary sediments. Recalling first the crystalline substances, let us recollect that many of these are of slight significance; for example, the crystals of triple phosphate, calcium phosphate and ammonium urate serve to indicate nothing except that the urine is in a state of decomposition. Other substances, such as cystin, jencin and tyrosin, are so rarely seen that we will pass them over to-night, and hurry on to the three most often seen in acid urine—calcium oxalate, amorphous urates and uric acid. Of oxaluria, the presence in excess of the first of these sediments, I am anxious to hear your opinion. Whether we are justified in assuming, as some have done, the existence of an *oxalic acid diathesis* which parallels the uric acid diathesis, I am not disposed to admit. It seems that in a majority of cases a persistent excess of calcium oxalate crystals in the urine is associated with a general neurotic state, which may justify us in believing that the oxalates are related clinically, as well as chemically, to uric acid.

The amorphous urates, with their brick-dust appearance, indicate, in reality, nothing more than an extremely acid and concentrated urine; and this is true, also, of uric acid crystals themselves. It is this same concentrated, acid urine, however, the discovery of which confirms our suspicion that the various more or less vague nervous, digestive, circulatory, respiratory and cutaneous symptoms of which a patient complains, are in reality due to the much-discussed and little-understood gouty diathesis. So long as we cannot, in a practical way, determine accurately the daily output of uric acid, we must continue to rely upon the association of this persistently concentrated urine with the various suspicious symptoms for our diagnosis.

Of the anatomical sediments, blood-corpuscles simply serve to indicate the occurrence of hæmorrhage somewhere in the urinary tract. The source may be in the kidney, the ureter, the bladder, or the urethra. The brighter the color

of the blood, the nearer its source to the meatus ; the more intimate its admixture with the urine, and the darker its color, the higher its source. In general, however, associated signs and symptoms are necessary to enable us to determine accurately whence comes the blood.

Pus-corpuseles, dead leucocytes, appear in very small numbers in normal urine. If they are abundant, however, an interesting and often difficult problem confronts us ; for, like the blood-corpuseles, they may arise from almost any point in the urinary tract. We must exclude the pus of leucorrhœa in women and of gonorrhœa in men ; we must decide whether or not it is due to cystitis, in which case the urine is apt to be alkaline in reaction ; and finally, if pus is mixed with acid urine, and there are casts or renal epithelium, or symptoms suggestive of renal disease, we have still to determine whether it is pyelitis, pyelonephritis, or tuberculosis of the kidney. It is a difficult, often an insoluble, problem ; and it is one which I will not attempt to discuss within the limits of the present paper.

Of the sources of the epithelium found in the urine, we do not speak as confidently as we did a few years ago. We no longer rely upon the form of the epithelial cells found to localize the lesion, although we know that in general the flat cells can be disregarded, coming as they do from vagina or bladder, and that the columnar cells come from the superficial layer of the membrane lining the renal pelvis, while the round cells may represent the deep layer of either the renal pelvis, bladder, or male urethra. At times these cells may, in connection with other findings, possess a very great diagnostic importance.

After all, however, the sediment to which we all attach the greatest importance is that containing casts. In general, tube-casts mean nephritis, although in some cases their temporary presence may be due to simple congestion, and some very able clinicians are inclined to attribute little significance to narrow hyaline casts occurring in urines which show no evidence of defective elimination. It is certainly a fact that casts can be discovered in the urine of practically every man who has passed middle life. Presumably, a certain degree of degeneration has begun in all organs by this time (we all know, for that matter, how impossible it is for a pathologist to find a perfectly normal organ), and the occurrence of a few hyaline casts need not be regarded as of serious import.

In the main, however, we are inclined to look upon tube-casts as the result of lesions of the kidney substance, and to attach the greatest importance to their discovery. In order to appreciate their significance, it is only necessary to consider their method of formation. A cast is formed by the exudation into the renal tubules of the coagulable portion of the blood. This mold of exudate may be thrown out pure—a hyaline cast. In many cases, however, it forms a matrix, in the substance of which the unattached *debris* present in the tubule becomes entangled. An understanding of this fact renders easy the interpretation of the meaning of each variety of cast. As we know, degeneration of the epithelial cells lining the tubules early leads to a granular change in each cell ; hence a cast thrown off early in an acute nephritis is largely made up of these desquamated epithelia. As the disease progresses and the process goes on, however, the epithelial cells are broken up into a mass of granular matter, which appears in the urine as a granular cast. This means a chronic degenerative lesion of the kidney. Finally, when the nephritis has gone on for a long time, and the tubules have become denuded of every vestige of epithelium, the cast can consist only of the exudate—and again a hyaline cast, in this case of greater breadth, results.

It is impossible to make dogmatic assertions as to the unvarying significance of each of these casts. Nephritis is never purely interstitial or purely parenchy-

matous; in every case the disease is more or less diffuse, involving all of the structures of the kidney. We can give it a name that explains the predominant pathological lesion, and that is all. Chronic interstitial nephritis is frequently complicated with an attack of acute parenchymatous nephritis, and as a result, epithelial casts, and even casts composed of blood-corpuscles, the result of actual hæmorrhage into the tubules, are not uncommon in the urine. Allowance must be made for such happenings as this, and the final deduction must be made from the persistent, predominant urinary characteristics, rather than from one or a few observations.

In short, we must remember, in connection with the results of urinary analysis, as in connection with single symptoms, that they are not in themselves diagnostic. The totality must ever be considered in diagnosis quite as much as in therapeutics, and the best clinician is he who never fails to take into account every detail of his case.

Proceedings of the New York State Homœopathic Medical Society.—The fiftieth annual session of the New York State Homœopathic Medical Society was a pronounced success from every view-point. About one hundred members and visitors were enrolled. The character of the papers presented, the spirited discussion of the same, the resolutions adopted, looking toward a betterment of the profession and a closer guardianship of the public health, were all encomiums upon the progressive spirit of the Empire State Homœopathic Medical Society. Harmony, earnestness and progress were most noticeably present.

President John T. Greenleaf, M.D., gave a short but able opening address.

The Secretary, DeWitt G. Wilcox, M.D., presented the bound volume of the Transactions, as embodying the minutes. Upon the acceptance of the same, he read an editorial which appeared in the Buffalo *Sunday News* bearing upon said Transactions, and which read as follows:

"From Dr. DeWitt G. Wilcox the *News* has received a copy of the Transactions of the Homœopathic Medical Society of the State of New York for 1901. It is a big book, over 300 pages. The fly-leaf bears in black letters this definition: 'A homœopathic physician is one who adds to his knowledge of medicine a special knowledge of homœopathic therapeutics. All that pertains to the great field of medical learning is his by tradition, by inheritance, by right.' This utterance of Dr. E. H. Porter, President of the Society in 1898, is 'ordered printed conspicuously in the Transactions every year,' and is significant. Its apparent meaning is that homœopathy stands for plus instead of minus now-a-days—the new school accepts the knowledge of the old, and seeks to add to it. Science has won its inevitable victory in the field of medicine. The factions that were intent years ago on discrediting what each other knew, are content to add each other's acquisitions to a common stock now. In this field of effort competition is succeeded by co-operation, or survived only in the form of rivalry in achievement. The world is better for homœopathy. It has moderated the old dosing and severe alterative treatment, external and internal. The world has been good for homœopathy, too. It has taught its advocates the lesson that medicine has been slow to learn in all ages—that a single principle is not all of nature, and that all knowledge pertaining to life and death is vital to a just application of any theory to the cure of disease."

Dr. W. B. Gifford, the Treasurer, presented his report, showing a balance of \$329.14 in the treasury. Such a balance, after the publication of five hundred volumes of the Transactions, the appropriation of two hundred dollars for drug provings, and the regular running expenses, is evidence of a live society.

Dr. W. S. Garnsey, the Necrologist, reported the deaths of Dr. Charles L.

Bonnell, Brooklyn; Dr. Henry Von Musits, New York City; Dr. H. C. Houghton, New York City; Dr. Henry Foster, Clifton Springs; Dr. A. E. Underhill, Brooklyn.

The thirteen following new members were elected: George H. Iler, M.D., Brooklyn; Walter G. Crump, M.D., New York City; LeRoy B. Sherman, M.D., New York City; John Hutchinson, M.D., New York City; G. DeWayne Hallett, M.D., New York City; Benjamin R. White, M.D., Honeoye Falls; Charles S. Winters, M.D., Binghamton; Walter G. Mead, M.D., Deposit; Charles W. Townsend, M.D., New York City; T. Drysdale Buchanan, M.D., New York City; Amelia Wright, M.D., Glens Falls; E. A. Simonds, M.D., Carthage; Arthur Ginnever, Glen Cove, N. Y.

Dr. John L. Moffat presented a report on the Increasing Interest in the Materia Medica, in substance as follows: "The response to our efforts has been so meagre, and the criticisms of our report so adverse, that it would seem advisable to form two committees next year of members who have not manifested any special interest in this subject. If they cannot tell us how they can be interested, to whom would it be logical to apply?"

Dr. Myron H. Adams sent, too late for our September report, the following verifications that are fixed in his mind by many years of experience, quoting from memory rather than copying them from the text-book: Alumina: Constipation, characterized by great inactivity of rectum, with hard round balls for stools (Bryonia). Argem. nit.: Time passes too slowly; also indigestion, flatulence, with sense of great distention, severe headache. Carbo veg.: Belching of gas soon after eating, the same mixed with sour, rancid food; great similarity to argent. nit.

Dr. E. H. Porter, on the Legislative Committee, reported the defeat of the Osteopathy bill, and the passage of the bill to discontinue Board of Managers for the State Hospitals, and placing the arrangement of the same in the hands of the Lunacy Commission. Although this was an administration bill (emanating from the Governor), yet it received the most pronounced opposition from all quarters of the State as being unwise, and tending to centralize too much power in the hands of political appointees; thus the distribution of five million dollars is made by a Board of Five Commissioners. We are, however, assured that our own homœopathic State hospitals shall not suffer by this change, as they must, by virtue of their charters, remain under the superintendency of homœopathic physicians.

After the reading of the paper by Dr. LeSeur, of Batavia, upon "Vaccination," the following resolutions were adopted:

Resolved, In the opinion of this Society, if, and when the State and local authorities enforce vaccination, they are in justice bound to surround it with all the modern safeguards.

Resolved, Public vaccinators should properly apply an efficient shield immediately upon vaccinations, with instructions as to its removal.

Resolved, That the virus used by them should, for each patient, be free from all possibility of contamination.

Dr. J. W. Candee, of Syracuse, offered a resolution looking toward a change in the By-Laws, whereby the Australian system of election shall be instituted. This is to be acted upon at the next annual meeting.

The election resulted as follows: *President*, John L. Moffat, Brooklyn; *First Vice-President*, M. C. Ashley, Middletown; *Second Vice-President*, Bukk G. Carleton, New York City; *Third Vice-President*, Charles A. Gwynn, Auburn; *Secretary*, DeWitt G. Wilcox, Buffalo; *Treasurer*, Frederick J. Coxe, Albany; *Necrologist*, W. S. Garnsey, Gloversville; *Counsel*, Frederick E. Wadhams, Esq., Albany.

The Committee for Nominating Candidates for Medical Examiners, consisting of R. A. Adams, B. G. Carleton, W. H. King, W. B. Winchell, Martin Besemer, nominated Willis B. Gifford, Wm. Morris Butler, Martin Besemer, W. M. L. Fiske, E. H. Noble, E. E. Snyder, H. W. Paige, H. D. Schenck, J. W. LeSeur, from whom the following names were elected to be sent to the Regents: To take place of Willis B. Gifford and Wm. M. Butler, Willis B. Gifford, Attica; Wm. Morris Butler, Brooklyn; Wm. M. L. Fiske, Brooklyn, and Martin Besemer, Ithaca. To take the place of Asa S. Couch, resigned, the following names were sent to the Regents: H. W. Paige, New York City; John W. LeSeur, Batavia.

The Committee for Nominating Medical Examiners for the ensuing year was elected, as follows: George W. Roberts, New York City; Lynn A. Martin, Binghamton, F. Park Lewis, Buffalo; H. D. Schenck, Brooklyn; Charles T. Haines, Utica.

Censors: Wm. H. Van den Burg, New York City; J. A. Stewart, Brooklyn, A. B. Van Loon, Albany; J. I. Dowling, Albany; W. H. Nickelson, Adams; C. A. Ward, Binghamton; J. M. Keese, Syracuse; W. H. Hodge, Niagara Falls; Geo. T. Moseley, Buffalo; J. D. Zwetsch, Gowanda. Dr. M. O. Terry, of Utica, was elected a Senior Member.

Dr. H. D. Pease, of the New York State Laboratory at Albany, addressed the Society on a subject of extreme interest regarding the preparation of vaccine and antitoxin.

The following programme was presented; out of thirty-three papers promised, twenty-nine were presented.

Tuesday Morning, February 11th.

10 A.M.—Prayer. Communications from the President, John T. Greenleaf. Appointment of Committees—Attendance, Auditing, President's Address. Tellers. Minutes of last meeting. Reports—Treasurer, Willis B. Gifford; Neurologist, W. S. Garnsey; Board of Censors; Election of New Members; Committee for Increasing Interest in Materia Medica, John L. Moffat; On Medical Legislation, E. H. Porter; On Life Insurance Companies, George R. Stearns. Banquet Committee, E. G. Cox. Delegate to the American Institute of Homœopathy. Miscellaneous Business.

10.45 A.M.—Bureau of Materia Medica, Walter T. Crump, Chairman. "Belladonna," Walter S. Mills. "The Seductiveness of Combinations," Alfred Drury.

11.15 P.M.—Bureau of Laryngology and Rhinology, H. W. Hoyt, Chairman. "Relation of Lymphoid Hypertrophy to the General System," F. Parke Lewis. "Treatment of Lymphoid Hypertrophy," J. F. Roe. "Catarrhal Preventives," Fred. D. Lewis.

11.45 A.M.—Bureau of Public Health, Howard P. Deady, Chairman. "The Public Health, a Sarcasm and Suggestion," Lynn A. Martin. "Vaccination," John W. LeSeur. "Colorado, Winter Sunshine," F. A. Faust.

12.15 P.M.—Bureau of Surgery, Homer I. Ostrom, Chairman. "Modern Anæsthesia," Anson B. Bingham. "Ulcers of the Leg," A. R. Grant. "The Surgical Treatment of Dysmenorrhœa," H. I. Ostrom. "Resection of the Metatarso-Phalangeal Joint," DeWitt G. Wilcox.

Tuesday Afternoon.

12.30 P.M.—Report of Medical Examiners. Bureau of Obstetrics, Frank W. Adriance, Chairman. "Rupture of the Fallopian Tube and Artery at Full Term and Immediately Preceding Labor," F. P. Warner. "Uræmic Eclampsia, some Facts and Observations," Arthur P. Powelson. "Placenta Prævia,

Uræmia, Grippe, a Combination Case," Geo. R. Stearns. "Pemphigus Complicating Pregnancy," W. S. Garnsey. Discussion by H. M. Dearborn.

3.30 P.M.—Bureau of Pædiatrics, H. E. Merriam, Chairman. "The Successful Treatment of the Most Fatal Diseases of Children," E. L. Hinman, "Effect of Regents' Examinations upon Nervous Children," DeWitt G. Wilcox.

4.00 P.M.—Bureau of Ophthalmology and Otology, Alton G. Warner, Chairman. "The Eye Complications of Measles," Chas. H. Helfrich. Discussion by George W. McDowell. "The Ear Complications of Grippe," J. Ivinney Dowling. Discussion by H. D. Schenck.

4.30 P.M.—Bureau of Clinical Medicine and Pathology, Charles A. Ward, Chairman. "A Remarkable Cure with the Single Remedy in a Single Dose Given High," George E. Gorham. "Diphtheria and Antitoxin," C. Gray Capron. "Pernicious Anæmia, its Etiology and Therapy, illustrated by a recent case," W. H. Van Den Burg. "Uricacidemia," Chas. A. Gwynn. "Fluoric Acid, its Pathogenesis," Charles S. Winters. (With invited co-operation.)

5.30 P.M.—Miscellaneous Business.

Tuesday Evening.

8.00 P.M.—Banquet at the Hotel Ten Eyck. All members and visitors cordially invited.

Wednesday Morning, February 12th.

10.00 A.M.—Report of Committee on President's Address.

10.15 A.M.—Bureau of Neurology, Geo. F. Adams, Chairman. "Neuritis," William Morris Butler. "Acromegaly, a Case," Morris C. Ashley.

10.45 A.M.—Bureau of Gynæcology, George W. Roberts, Chairman. "The Physical Signs and Treatment of Gonorrhœa in Women," L. L. Danforth. "A New Radical Method of Performing Proctectomy for Cancer in Women," Geo. W. Roberts.

12.00 M.—Elections. Of Officers; of four or more Nominees as State Medical Examiners; of Committee to Nominate State Medical Examiners.

12.30 P.M.—Miscellaneous Business. Report of Committee on Attendance. Unfinished Business. Adjournment.

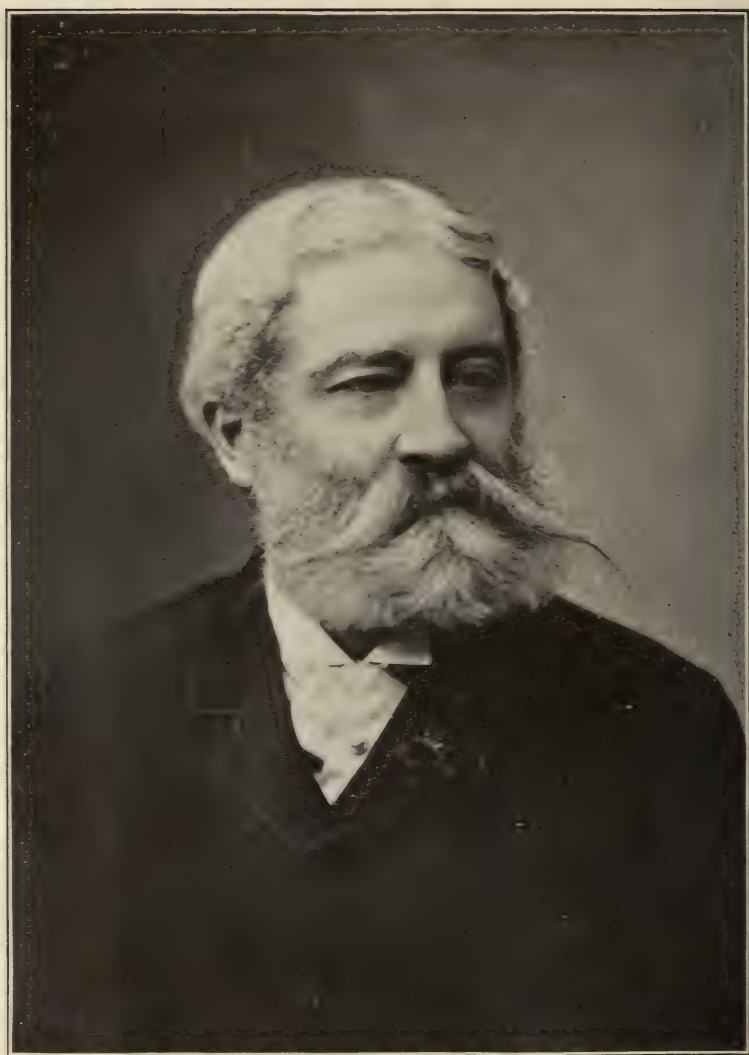
Western New York Homœopathic Medical Society.—The Eighteenth Annual Meeting of the Western New York Homœopathic Medical Society was held in Buffalo, April 11, 1902. The programme was as follows: President's address, Newton M. Collins, Rochester; "Some Thoughts on the Study of the *Materia Medica*," A. B. Rice, Jamestown; "Diabetic Coma," S. W. Hurd, Lockport; "The Use and Limitations of the Sphygmograph, with Remarks on Vascular Tension, with Special Reference to the Treatment of Cases of Failing Heart," Clarence Bartlett, Philadelphia; "Chloroform Poisoning: A Case," Burt J. Maycock, Buffalo; Prophylaxis is to be Realized Through the Attainment of Health, Not by the Propagation of Disease," J. W. Hodge, Niagara Falls; "Exophthalmic Goitre," W. B. Gifford, Attica.

The following officers of the Society were elected for the ensuing year: *President*, Dr. Emily F. Swett, Medina; *First Vice-President*, Dr. Fred. D. Lewis, Buffalo; *Second Vice-President*, Dr. A. B. Rice, Jamestown; *Secretary-Treasurer*, Dr. George R. Critchlow, Buffalo.

The evening session consisted of a supper at the Markeen, and the occasion was graced by the presence of the ladies of the Society. During the afternoon of the meeting, Mrs. Park Lewis received very informally the ladies from 4 to 6 o'clock.

An amendment to the by-laws, providing for the holding of two meetings a year, instead of four, as at present, was defeated by a decisive vote.

G. R. Critchlow, M.D.,
Secretary.



Wm. God. Helmuth

THE HAHNEMANNIAN MONTHLY.

JUNE, 1902.

RACHITIS.

BY J. ROBERSON DAY, M.D., LONDON.

Physician for Diseases of Children to the London Homœopathic Hospital.

ONE almost feels inclined to offer an apology for an article on such a common and well-known disease as rickets, and yet it is sometimes this very commonness that leads to neglect; else why should we see so many rickety children suffered to grow up deformed and uncared for?

It is essentially a disease incident to civilization—an acquired disease, as opposed to an inherited disease. It is possible for *any* child to become rickety; a child born of unimpeachable parents (as regards their health) can be made rickety by disobedience to the laws of health, as we occasionally see when a perfectly healthy child born out of wedlock has been handed over to a woman to look after at five shillings a week! We all know the class of patients who come to our hospitals with long-tube bottles, containing a sour-smelling, bluish-white fluid called “milk,” swathed in a bundle of filthy clothes, dirty, unwashed, pale, emaciated—but not always; for, if the diet has been starchy, they may be fat, with beads of perspiration on the forehead—the home (mark the word) in which they live a miserable tenement in a back court, where evil odors prevail, and the fresh, sweet air of heaven never penetrates. Such are the conditions which favor rickets, and are briefly summed up in bad air, bad hygiene, bad food.

Yes! it is possible for any child to become rickety; and the same applies to the brute creation, where experiments are possible. Puppies who have been brought up on meat and starchy food become rickety; and all young animals, if deprived of milk, their natural food, and fed on other things, develop rickets.

From time to time we hear of *fœtal* rickets and congenital rickets, but no well-authenticated cases are known. Cases of achondroplasia have been mistaken for congenital rickets.

The age at which rickets most usually occurs is between six months and two years—just that period of life when the diet of a child is of the utmost importance.

The pathology is especially instructive, for it explains so many of the symptoms. It is essentially a *general* disease, and not a disease of the osseous system only, although the brunt of the disease falls on the bones, which are deficient in lime salts—as it were, decalcified, so that they readily bend. The growing ends of the bones are most conspicuously affected, between the shafts and epiphyses. Here there is an exuberant overgrowth of soft, unossified bone, which produces the enlarged ends at the wrists and ankles and the beading of the ribs. The sutures of the skull are late in uniting, and the anterior fontanelle remains open beyond the second year of life. The teeth, also, which are composed almost entirely of earthy salts, are late in appearing, and, when they do come, decay early, as they are soft and brittle.

Errors in diet, so largely the cause of rickets, lead to intestinal fermentation and great distention—hence the pot-belly. The rickety curves in the bones are due to the same cause. The soft bones yield to pressure, and bend according to the way they are handled. It is of the greatest importance that these children should not be allowed to walk too soon. Fortunately they are late in making the attempt from very weakness; but even when they do, they should be restrained, or bow-legs and knock-knee will result, associated with flat-foot. Green-stick fracture occasionally takes place, and it occurs so easily that at the time it attracts no notice.

I saw this morning (April 17, 1902) a child aged two years, whom the mother brought to me with what she described as a “bone growing out of the neck.” On examination, I found

both clavicles had been fractured and had united at an acute angle, and "the bone growing out of the neck" was really the seat of the fracture, which had united, producing this projection.

This softness of the bones is the cause of deformity of the chest. The ribs yield to pressure where least supported—that is, above the liver and spleen, and at the insertion of the diaphragm. This causes the transverse grooves to which Harrison drew attention, and which bears his name. During inspiration the ribs can be seen drawn in at this part. The lower costal border is everted by the pot-belly and enlarged viscera. The sternal ends of the ribs are beaded. This is a most constant sign of rickets—the so-called rosary.

The health of the child is profoundly depressed, so that bronchitis is common. Rickets and bronchitis are a very frequent cause of death in the winter months.

The digestive organs are always out of order; there is much flatulent distention of the bowels, owing to intestinal fermentation and lack of muscular tone.

These children perspire freely, and, during sleep, beads of sweat stand on the forehead and a halo of moisture wets the pillow. They dislike being handled, and sit all of a heap, with back bowed, and seem to suffer from a general tenderness, crying out when touched. The liver and spleen are commonly enlarged; and the pot-belly, with frequent slight umbilical hernia or eversion of the navel, completes the picture. Both forearms and tibia are frequently curved.

The consequences of rickets are far-reaching, and, if treatment is neglected, lead to dwarfing of the stature and flat-foot or bow-legs. The most serious deformity is contraction of the pelvis, and this is one of the commonest causes of dystocia in after-life. Fortunately, much can be done by treatment; and, if the case is seen early, a cure may be confidently predicted. Medicinal, dietetic and general treatment all play a very important part.

Calcarea in high potency is what I always prescribe, as calc. carb. 6, gr. ij three or four times a day, or calcarea in combination with iodine or phosphorus, as calc. iod. 3 or calc. phos. 3, giving them according to the indications in each case. Frequently some other disease is present as well,—*e.g.*, congenital

syphilis,—and in this case I combine the above medicines with inunctions of unguent. hydrarg. (B. P.).

Cod-liver oil, which stands midway between a medicine and a food, is of great value, and can be given in teaspoonful doses, thrice daily. Good cows' milk in abundance should form the principal food, which should be modified according to the age of the child. Generally, rickety children are bottle-fed; breast children are rarely affected with rickets—that is, up to nine or ten months of age. But prolonged lactation may produce rickets. These children are flabby, and need the proteid element of their food increased, which can be best done by adding some form of raw-meat juice. I generally order bovine; 10 to 15 drops in each bottle has a wonderful effect in making the muscles firm. It is liable to cause diarrhœa, so the quantity must be varied and the effect watched. Regularly washing the child to keep the skin acting is of the utmost importance. A warm soap-and-water bath each night and a tepid or cold sea-salt bath each morning, followed by general massage for ten minutes, greatly helps recovery. Fresh air and sunshine are all-important, and an out-door life should be insisted on.

I have already alluded to the deformities which may follow rickets, that which is most common being bow-legs. The usual practice is to use splints, but I find them unnecessary in the large majority of cases. My plan is to bind the legs together with a domett flannel bandage, $2\frac{1}{2}$ inches wide. Beginning at the feet, take a few turns of the bandage over the ankles, and then carry it well over the knees, padding with cotton-wool, when necessary, to avoid friction. It is a very satisfactory method of treatment; the one leg forms a splint for the other; moreover, it serves a further purpose by keeping the child from walking. The bandage must be removed at bedtime, and reapplied in the morning after the sea-salt bath has been given and massage and movements used. It is possible to do much by daily trying to straighten the curves with the hands; the soft bones gradually yield to pressure. If this treatment is kept up for six or eight months, the straightness of the legs is restored.

Flat-foot must be treated by movements designed to strengthen the weak arch, and walking on tip-toe, and later on

skipping, should be practiced. Skipping is excellent for expanding the chest, the rope being thrown *backwards*. Deep breathing is of great value in expanding a flattened chest, and Swedish exercises will greatly help in restoring the natural form.

HOW TO SAVE THE PERINÆUM BY THE DELIVERY OF THE ANTERIOR SHOULDER FIRST.

BY G. MAXWELL CHRISTINE, M.D., PHILADELPHIA.

Attending Obstetrician, West Park Hospital for Women, Philadelphia.

ON various occasions I have inquired of obstetricians and general practitioners which shoulder, anterior or posterior, in vertex presentations, they seek to deliver first. On the day this article is being written, my question was answered for the first time with positiveness and directness by a fellow-practitioner, who replied, without hesitation, "the anterior shoulder,"—that is to say, the shoulder presenting under the pubis.

It occurs to me that a few years ago I read an article on this subject, but an extended search among my pamphlets has not rewarded me with finding it; my recollection, however, is that the writer of the article had a similar experience with mine, and that he could get very few, if any, to answer that they paid any special attention whatever to a particular shoulder to be delivered first. The author, if my recollection serves me correctly, favored the anterior shoulder. The article passed out of my recollection, and for a long time the idea went with it.

One of the hobbies I have ridden in obstetrics has been the protection of the perinæum. I once wrote a paper on the subject, stating that for over a year I had had no torn perinæums. For a long time after the paper was published I tore nearly every perinæum I encountered. I adopted all known methods for its preservation, but none got me back to that lucky year.

There are times when, in spite of all care, the perinæum will be torn.

Some of my cases, even in the presence of apparent caution, which, however, has often proved delusive, have had even complete tears, and have otherwise all gone wrong.

These exceptions do not, however, make the rule; but they do make us pause and ask ourselves as to why they so happen. If we are content with bad results we do not attempt to furnish an answer, and we call our misfortune "bad luck." If we are bent on allowing no ill experience to repeat itself, we pause for an investigation of our methods. Often this process of trying to get at the cause is followed by no more "bad luck" in that direction, because, after a study of our methods, we have found a cause for our failures, and have fortified ourselves against their repetition.

The perinæum, in my obstetrical cases, is never torn without a careful rehearsal by me afterward of the methods I have pursued, and never without an honest endeavor on my part to assume my full share of blame for the occurrence.

I am still studying the subject, and, unfortunately, am still allowing some of my perinæums to be torn. I am not ready to believe that any one method or series of methods has been devised which will certainly insure protection for the perinæum against rupture. A clear understanding of the anatomical character of the structures of the vaginal outlet, liable to rupture and stretching, coupled with the individual characteristics of the parts, such as rigidity, unusual narrowing, etc., will, when associated with the anomalies of labor, such as non-rotated occipito-posterior head presentation, etc., cause us to have less confidence in our skill to ward off rupture, and will also make us all the more ready to confess our comparative helplessness in the presence of the inevitable.

Some one long ago devised the simple operation of episiotomy—lateral incisions in the perinæum—in that class of cases where the perinæum presents all the essential aspects of an ensuing tear. This operation, so useful, but not often enough employed, was simply the outcome of an experience which, like our own, was not satisfied with existing methods, and sought new solutions of a problem all-important to the future integrity of the maternal parts.

In a primipara, in whom the levator muscles and the perineal body have the ordinary firmness, excellent opportunity is given us for watching the process of distention as the on-coming head advances against the firm muscular pillars passing up on each side of the vagina, and finally as the head impinges on

the perineal floor and distends the fourchette. With the advancement of the occiput up from under the pubis, if we hold our fingers against the stretched muscles on either side, we will feel them give, and finally yield. In some instances the yielding gives the distinct sensation of a tear, which may or may not be subsequently superficially apparent. If the advancement of the head has been slow, and the muscular vaginal entrance has been stretched by the operator, as labor advances, into a more pliant condition, which is all the more easy under anæsthesia, this tearing, usually inevitable under a let-alone policy, can often be prevented.

But the observation I have mentioned is instructive, and, to the obstetrical practitioner who considers it worth his while to have a technique which he can justify, and of which, by reason of results, he can boast, it is most profitable.

To me, the mechanics of labor is one of the most instructive in the field of medical art, and one object of this somewhat general paper is to urge upon the practitioner a little more study and consideration of the subject than is usually given it. It is an old subject, but it is an ever-abiding one; and, as the statistics of our clinics show the existence of numerous torn and stretched vaginal outlets following labor, its importance as a matter of discussion cannot be regarded any less now than it ever was.

This article is not written for the purpose of giving in detail all the methods to be employed to prevent disaster to the vagina in labor; but, in addition to an aim to arouse renewed thought in the matter, its purpose is to refer to the question with which the article starts out: Which shoulder, anterior or posterior, pubic or sacral, in head presentations, should, as a rule, be delivered first? My answer is the one given by the practitioner already mentioned, who stated that he delivered the anterior or pubal shoulder first.

It matters little to the child, except occasionally, as to whether it enters the world with one or the other shoulder first; but, if my theory is correct, it often matters much to the mother, for the reasons I now give.

My observation has been, that what the head has not accomplished in the act of muscle-rupturing, the shoulder passing over the perinæum, and, perhaps, though in a slighter degree,

the hip, does effect. A feeling of annoyance has always been associated with these after-head tears, and in the effort to do away as much as possible with the cause, two or three years ago I recalled the article I had read on the shoulder question. It is impossible for me to state whether the author gave any reason for the delivery of one shoulder rather than the other, but my reason for so doing is that in delivering the anterior shoulder first we the more readily protect the perinæum against injury from that source.

Assuming a case in which the head has glided safely by the side muscles of the vagina, and has lifted itself over the perinæum, the neck of the child now rests on the perinæum; the posterior shoulder is on the vaginal floor, and is pressing, during pains at least, in an outward and downward direction against the perinæum. In the delivery of the head the resultant of the forces is outward and upward, in the direction of the continuation of the parturient curve; but as soon as the head is delivered, the trunk takes the place of the head, and the direction of expulsion is somewhat changed to one which tends to jam the lower or posterior shoulder against the raised perineal body and fourchette, if they have been left wholly or partially intact. If this direction is not changed, a tear is almost inevitable.

Frequently the contractility of the outlet relaxed by the obtruding foetal head is quickly restored and the neck is firmly encircled by the perineal muscles, behind which are the shoulders.

At this period the attendant is apt to view the situation with anxiety. The child's face is becoming blue, the maternal efforts have ceased or have greatly eased up, and the shoulders are wedged behind the contracted outlet. Delivery at this time should be prompt. With the head delivered and the shoulders unborn, many foetal lives have been lost in the delay, due to strangulation of the neck. Unless delivery is quick, and the shoulders immediately follow the head over or through the perinæum, which is lax or has been torn recently or anciently, it is obviously impossible to deliver both shoulders at the same time—one or the other must advance first. If the posterior shoulder is first delivered, it must be by reason of the anterior shoulder being restrained under and behind the pubis, the

result of the propelling forces being to carry the child up and forward in the direction of the axis of the parturient canal, which means that the already delivered fetal head shall also be carried along this imaginary line, which is contrary to the laws of gravity.

If the labor is quick, this is the usual mechanism, with consequent perineal rupture; but in ordinary labors, where, after the delivery of the head, there is a rest given to the maternal forces, which interval is evidently designed to enable these forces to reorganize themselves for further effort, the head now falls over the perinæum, as already pointed out, which would seem to indicate nature's intention with respect to delivery of the shoulders—namely, that the posterior shoulder shall be restrained, and even forced back, by the sagging downward of the head. Now, if this manifest intent is utilized, and the patient is drawn by the attendant over the edge of the bed or table in the dorsal position, with the buttocks freely overhanging, the head of the child should be forcibly pressed downward, while slight traction is exerted which communicates itself to the anterior or pubic shoulder, the woman being urged to bear down, while the nurse is grasping the fundus of the uterus through the abdominal wall and following its contraction as the child is expelled. The anterior shoulder is brought by this manœuvre from under the pubis, and the posterior shoulder is forced back from the perinæum toward the hollow of the sacrum.

The amount of traction and downward pressure needed to be employed in this procedure is sometimes considerable and may alarm the beginner, but after one or two experiences this fear will subside, and the operator will become quite skillful in the manipulation. It is essential to have the patient well over the edge of the bed or table, in order to give room for the downward movement of the head.

The shoulder, as it presents above, can be hooked under with the operator's finger, and considerably aided in the delivery. The arm can then very readily be brought out, and we now have a condition in which the anterior arm and shoulder are free in front of the pubis, the neck of the child rests on the perinæum, and the lower shoulder is within the vagina posterior to the muscular bulwark.

Rotation of the shoulders and trunk can now be readily effected, which swings the original anterior shoulder over and outside of the perinæum, and raises the former posterior shoulder up under the pubis. It is now an easy matter to deliver the anterior shoulder—in fact it is usually delivered, in the transit of rotation, before it reaches the pubis.

The philosophy of the mechanism, as I suggest it, is to have all the fœtal parts likely to tear the perinæum sweep up toward and from under the pubis, and thus furnish the needed protection to the perinæum. I do not claim any originality in the matter, but believe I am almost alone among obstetricians in making the procedure I suggest a rule of action with a specific purpose in view.

It is perhaps needless for me to state that there are instances in which no fixed rule will apply; propulsive pains are uncontrollable, or, in using forceps, traction suddenly meets with non-resistance, and the child is delivered into the world with a rush, tearing everything before it in spite of all efforts to control it.

I am hopeful this article will elicit discussion in the matter, which should be profitable.

Summary:

1. Seek to deliver the pubal shoulder first.
2. Bring the patient far over the edge of bed or table.
3. After the birth of the head, restrain the propulsive maternal efforts while the head is being depressed, restore the posterior shoulder to the hollow of the sacrum, and bring the anterior shoulder from under the pubis. Aid the delivery of the pubic shoulder and arm by a finger in the axilla.
4. Sweep the pubic arm from under the pubis, and then secure rotation of the shoulders, the anterior shoulder gliding down and over the perinæum, while the perineal shoulder is swung upward and outward as it reaches the pubis.

In my obstetrical practice this procedure has saved many perinæums.

THE BACILLUS TYPHOSUS, WITH THE WIDAL REACTION.

BY O. H. PAXSON, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of Philadelphia County, Feb. 13, 1902.)

THE bacillus typhosus, or the bacillus of Eberth, if we wish to honor the man who discovered it, is a very actively motile organism, about three times as long as it is broad, with very delicate organs of locomotion, in the form of fine, hair-like flagella, attached in large numbers to all parts of its surface. It is sometimes seen as short ovals, again as long threads. This description alone is not sufficient to enable us to recognize it.

Gaffky isolated it in pure culture, thus making it possible to investigate and record its peculiarities of growth upon culture-media, and its reaction with blood-serums.

Its growth in culture presents many interesting features to the bacteriologist, and to us as physicians. The only point to which I will refer, on this part of the subject, is the temperature at which it may be grown, and the degree of heat with which it may be destroyed. It grows best at temperatures of 36° to 80° F., and ceases to grow and is killed at a temperature of 110° F.

It is found both within and without the human body—without, in the water of polluted streams and in some of our food-supplies; within, it has been found in the blood, urine and fæces during life, and after death it may be found in the tissues of the liver, spleen, kidneys, and the intestines. It is not easy to demonstrate this organism in tissues unless it is present in large numbers. The spleen is probably the best tissue from which to obtain a specimen. In searching for the bacilli in such a specimen, it must be borne in mind that they are deposited in clumps; otherwise, much time is lost in searching for them. It may be that this clumping is analogous to the agglutination which is obtained with a positive Widal reaction.

To obtain a pure culture of the bacillus typhosus is the first essential in performing the Widal reaction. It has been found very difficult to isolate this organism so that its identification

may be positive. It must be remembered that it is so similar to a group of other organisms, to which it appears to be related, that it may be easily mistaken for them. The colon bacilli and other saprophytic bacteria are the ones most likely to be differentiated. Cultures from fæces, sewage, and infected water, are very likely to be contaminated by these non-pathogenic organisms. Even the stool of a typhoid-fever patient, owing to the presence of the normal inhabitants of the intestinal tract, may be a troublesome source from which to isolate these bacilli in pure culture. To differentiate these different bacilli, the pathogenic from the non-pathogenic, is a tedious process. It was the search for a more reliable means of differentiation and identification that led to this Widal reaction.

It was observed that, if a questionable culture of bacilli was brought into contact with blood-serum from a typhoid-fever patient, in some instances there would be an agglutination and clumping of the bacilli, with complete loss of motion; in other instances this was not so. Finally, it was found to be almost constant with the bacilli typhosi. So that, by employing it conversely, that which was at first used as a means of identifying the typhoid bacillus has become "Widal's serum diagnosis of typhoid fever."

After deciding upon a suitable culture, the next step is to inoculate half an ounce of sterile bouillon, in a clean test-tube, with some of the bacilli from the culture just mentioned. Use a sterile platinum loop to scrape some of the bacilli off, and then gently agitate it in the bouillon in the test-tube. It is then set aside for twenty-four hours, being kept at a temperature of 68° to 72° F. It has been found that when cultivated at a higher temperature the bacilli are smaller, making it more difficult to follow their active motions.

Specimens grown at a temperature of 70° F. will show their slow, gliding motion, enabling them to be studied with ease.

To prepare a hanging drop, carefully clean a cover-slip and cell-slide, and paint a marginal ring of cosmoline around the cell. With a sterilized platinum loop, carefully remove from the bouillon culture a drop and place it upon the cover-slip, after which the cell-slide is inverted over it, painted side down. Reversing the slide gives a hanging drop, which may be placed

upon the stage of the microscope and examined. If it shows a clear field, with actively moving bacilli, it is satisfactory, and is marked for a control culture. A similar mount of slip and slide is made, but without putting them together.

Blood for examination may be drawn from either the finger or the lobe of the ear. Cleanse with alcohol the surface to be pricked and make a quick puncture. Do not press the parts to hasten the flow, as it is *blood-serum* you want, rather than blood-corpuscles. The serum and blood is blotted off with either a piece of clean, unglazed paper, or else upon a clean cover-slip, and allowed to dry. Take with a sterile platinum-wire loop a drop of sterile bouillon, distilled water, or physiological salt-solution, and moisten a drop of the dried blood with it. Rub them gently together until the two are thoroughly mixed. Select, for this purpose, the lightest colored part of the blood, as in this we have the most serum, while the bright part of the blood will give the most corpuscles, which, as I said before, is not so desirable.

Taking some of this mixture with the platinum loop, add it to the drop of plain bouillon upon the cover-slip that has been previously prepared. This method of dilution is not accurate, but it is estimated to correspond roughly with a fresh blood dilution of from 1 : 15 to 1 : 20.

The fresh-blood serum is a more delicate test than that of dried blood, and is to be used in doubtful cases, in which all the available clinical evidence is opposed to either the positive or negative results of the test. To make this test still more delicate, the serum should be diluted from 1 : 50 or 1 : 60, and the exposure maintained for two hours.

With the dried blood, a positive reaction may be had at once; or, as is oftener the case, sometimes within an hour. A decision should not be made, where there is any doubt as to the reaction, until it has remained an hour under examination.

A typical reaction is one in which the actively motile cells gradually lose their motion, then cease to move, and finally are found clumped together in large or small agglutinations.

Pseudo-reactions are those in which there is more or less of clumping of the bacilli and a diminution of motion without complete cessation of movement; or, again, where there is complete loss of movement without clumping and agglutination.

Abbott says, of this reaction, that "in the great majority of cases, so far as experience indicates, it is specific; *i.e.*, a typical reaction does not occur between typhoid serum and organisms other than the typhoid bacillus, nor between the typhoid bacillus and serums other than those of typhoid fever."

The blood of certain animals, as well as a number of certain chemical substances, cause agglutination of the typhoid bacilli; but the reaction is not specific, for, in most cases, they have the same reaction on other bacilli.

In his report upon 12,000 examinations from about 10,000 febrile conditions, at the Municipal Laboratory of Philadelphia, he found a discrepancy of only 2 to 3 per cent. between the clinical and the laboratory diagnosis.

He concludes with the statement "that the test is yet in the experimental stage, and there are still numerous features not entirely clear. In the light of present experience, however, it is fair presumptive evidence that the serum is from a case of typhoid fever when unmistakable agglutination and cessation of motion are seen in from fifteen to twenty minutes after typhoid bacilli are mixed with the serum of a suspicious febrile condition."

Simon, of Johns Hopkins Hospital, says that the majority of observers are quite unanimous in affirming that the reaction is only observed in connection with typhoid fever; that the reaction observed in various other diseases, few in number, will show, quite likely, with future investigation, that the positive results obtained are referable to some error in technique. He concludes with the statement that only a positive result is, however, of value.

Cabot's collection of 5978 cases gave a positive reaction in 97.2 per cent. In 849 cases he obtained a positive reaction in all but 60 before the *eighth* day.

From the above evidence, and also from the evidence of many others equally trustworthy, there can be no doubt that it is a reliable means of diagnosis of typhoid fever, and that, too, in the early stage of the disease, when there is the greatest uncertainty.

Let me urge the importance of making more than one test before condemning it, especially if the dried-blood method is used.

SOME COMMENTS ON THE DIAGNOSTIC FEATURES OF PLEURAL DISEASES THAT MAY REQUIRE SURGICAL INTERVENTION.

BY EDWARD R. SNADER, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of New York County.)

It is a matter of common experience that the diagnosis of diseases affecting the pleura and its cavity and the adjacent lung is not always an easy matter, except in a fair proportion of perfectly typical cases. The men who make a specialty of thoracic diagnosis know this fact far better than the average every-day practitioner, to whom all is plain sailing, and who, in many of his cases, makes a shrewd guess, rather than a diagnosis, of a thoracic affection. When the question of the possible necessity for the employment of surgical measures arises in a certain class of these cases, the difficulties attending the making of a correct diagnosis are enhanced tenfold, for no one with a proper respect for his patient and himself wants to stick a knife in where it is not needed, nor does he want to stab in the wrong place for the right disease.

We clinicians are very, very fond of surgery when we can do nothing with drugs or other therapeutic measures; but we also candidly confess to a feeling of something akin to disgust when we think of the many so-called "exploratory incisions" (?), for we ought to know enough to be absolutely certain of our ground before we turn the case over to the surgeon. Notwithstanding, however, this feeling of disgust at our lack of positive knowledge along certain lines in physical diagnosis, I know that in a certain class of cases this contemned exploratory incision with the knife or trocar is a necessity, and, therefore, the only common-sense thing to do.

This necessity, however, could often be avoided if diseases would only follow text-book pictures of the diagnostic features of thoracic affections; but disease, so far as it manifests itself in physical signs, is as crotchety and variable as is humanity itself.

Perhaps the most deceiving physical condition respecting its physical signs is a considerable accumulation of fluid in the

pleural cavity. The text-books make a very pretty array of physical signs diagnostic of the presence of this liquid; but I have had a surgeon refuse to perform even *parentesis thoracica* because these classical signs were not present, on the ground that, with just such a series of signs as were in evidence in the case I proposed to have explored, he had operated and had found no fluid, but had produced a pneumothorax; and in another case had punctured the lung and induced hæmorrhage by the mouth; and, in still another, sudden death had resulted. I have learned, therefore, that the dear little, peaceful, innocent, Quaker-like operation of thoracentesis has terrors of its own for the white-robed, gore-seeking hewers of flesh and drawers of blood. This, too, despite the fact that the text-books almost universally commend the operation and minimize its consequences. In all these cases, however, in which the signs were not classical, but in which I persisted in the diagnosis of fluid in the pleural cavity, subsequent developments, either with the assistance of surgery or through the medium of the occurrence of an *empyema necessitatis*, confirmed the diagnosis.

In the vast majority of instances in which there is fluid in the pleural cavity we do not require surgical intervention. This is notably true of ordinary pleural effusion and the serum of hydrothorax. Indeed, the less we have to do with surgery, and its shocks and sepses, the better for the patient. I do not know why the pleural cavity shows such a pronounced tendency to infection after operation, but certainly such a tendency exists. But, with pus in the pleural cavity, in ninety-nine cases out of one hundred we want surgical intervention, and we want it quickly. Every-day pleural effusion may be a medical disease, but pus in the pleura is ever and always a surgical malady. The other affections in which there is fluid in the pleural cavity,—as ordinary effusion, hydrothorax, pneumo-hydrothorax and pneumo-pyothorax,—may also occasionally require to be treated surgically.

Now, in some instances, particularly in adults, the diagnosis of liquid in the pleural cavity is one of the easiest tasks in the whole realm of physical exploration; but, like all other methods of diagnosis that have to do with the almost infinite capability of variety—kaleidoscopic variety—shown in mere physical conditions, the presence of this fluid may be very difficult to

detect. When the classical physical signs of marked dullness on percussion (flatness), absent vocal fremitus, absent vocal resonance and absent respiratory murmur, together with movability of the upper line of dullness, are the physical signs in evidence, the chances of fluid being within the pleural cavity are so great that I would risk puncture for that fluid without feeling it necessary to say my prayers twice in one night and four times during Lent. Barring the single sign of the movability of the upper line of dullness, the only other physical conditions that could be present with those signs would be tumor, complete lung consolidation, and an enormously thickened pleura, with a lung unexpanded, rolled up in a ball, and anchored by adhesions (remaining after the absorption of fluid exudate following every-day pleurisy). If the bronchial tubes were pervious, so that they were in no way blocked or compressed, and so that the voice, as well as the breath-sounds, could travel down to the seat of suspected lesion, I should rule out any ordinary cause for the lung consolidation other than that due to the compression upon the lung of a fluid in the pleural cavity. If the upper line of dullness were movable, I would not need to determine the patency of the bronchial tubes, for the only thing that would move with the position of the patient would be fluid. However, every physical diagnostician who has had much to do with practical diagnosis knows that this movability of the upper line of dullness is a rare physical sign—so rare, indeed, that it is seldom looked for, although in a passive dropsy in the pleural cavity, as in hydrothorax, this sign is far more frequently available than when the fluid is present as the resultant of inflammatory processes. If, then, we have ruled out an intra-vesicular lung consolidation, the next point to decide is whether these physical signs indicate a tumor. If the tumor occupies the major portion of one pleural cavity,—its lower portion,—and there be no tumor elsewhere, and no pressure symptoms, the only available data to differentiate the fluid and tumor will be the shape of the upper margin of the tumor to percussion, and to auscultation of the voice particularly, which, by its alterations, may give you the exact upper outlines of the tumor. It would, indeed, be a strangely shaped tumor whose upper margin would present the same characters

as those due to fluid. If the tumor does not fill the entire cavity, the percussion note at the sides, perhaps, will show that the consolidating element producing the physical signs is not fluid; for, unless encysted, fluid will mechanically occupy the lower part of the chest on the affected side universally; and; if the fluid be encysted, there will still be left, in a portion of the chest, signs indicating that fluid has at one time occupied other parts of the chest in the vicinity of the encysted area, such as a dull percussion note with a perfectly normal or slightly exaggerated respiratory murmur, and an increase in the vocal resonance, and fremitus—all these latter signs arising from the thickened pleural membrane left after the fluid has been absorbed from the portions of the chest from which the signs are derived. It must not be forgotten, however, that a tumor in the pleura, or encroaching upon it, may give rise to either a passively produced fluid in the pleural cavity, from pressure on the vessels and lymphatics, or to an actual inflammation of the membrane, with subsequent accumulation of serum or other liquid. While these combination-cases look exceedingly difficult of diagnosis, practically I have not yet met with a case in which the tumor was discovered only after the fluid was removed. There have always been some pressure symptoms, or growth in a nearby organ, or symptomatic phenomena, that gave me the clue to the fact that, while the physical signs apparently indicated only fluid, there was something else encroaching upon the pleural cavity besides liquid.

Displacement of the heart, when present, is also of great value in determining the presence of fluid in the pleural cavity, although this displacement may also occur with tumor.

In practice, perhaps the most frequent differentiation necessary is between a lobar pneumonia affecting a lower lobe and a moderate pleural effusion. At certain stages, in certain cases, in both affections, the physical signs alone, without symptoms, are seldom sufficiently distinctive for differentiation for surgical purposes. Here some little reliance may be placed upon the character of the upper line of dullness. If the line of dullness follow the line of the interlobar fissure, the case is one of croupous pneumonitis. Classical lobar pneumonia, however, is a malady of the text-books, and it is only rarely that

the whole lobe is so equally consolidated that percussion can distinctly map out the lobe and nothing else. The disease would be better named gross pneumonia, rather than lobar, in many cases. If rust-colored sputum be present, you may know you have a pneumonia, but you do not know that you have not at the same time a pleural effusion. If the bronchial tubes are patent, and the ordinary signs of fluid are present, I should not hesitate to interfere surgically, if deemed necessary, on the supposition that the pleura contained liquid. Fortunately there is seldom any necessity to intervene surgically so early in the case. I recall, however, in this connection, a case of the most horrible dyspnoea it has ever been my lot to witness, occurring in a man whose right pleural cavity became completely filled with fluid within six hours after the onset. The diagnosis, even in this case, was not clear until after five hours had passed, for the onset was atypical and suggestive of croupous pneumonia, beginning with a decided chill and a temperature of one hundred and six degrees, Fahrenheit. At that time I did not know as much about physical diagnosis as I do now, or I might have been tempted to let the fluid out as fast as his disease poured it in.

So much for the classical signs of fluid within the pleural cavity. These signs—the marked dullness on percussion, and the absence or decided diminution in the vocal and respiratory signs—we often meet with clinically, and when met with, and there exists any necessity for surgical intervention, I think we are more than justified in proceeding with the contemplated measures for relief. The rub comes, however, when these signs are not present, and, instead, we find increased fremitus, increased vocal resonance and bronchial breathing, and the whispered signs of consolidation of the lung, in contradistinction to those indicating liquid. These signs, ordinarily indicating lung consolidation from intravesicular causes, do occur in a certain number of cases in which there is fluid in the pleural cavity, and no lung consolidation whatever save that due to the compression of the fluid; and this fact is the cause of frequent errors of omission and commission. The only way in which a diagnosis can be made in this class of cases is to take in the whole picture, symptomatic and physical,—to take in every factor in the case, including the history, if that is available,—

and to diagnose each case on its own merits, and not at all with reference to the physical sign indicating fluid which you have found in some other case, for there are all sorts of physical signs, and all sorts of combinations of them, to deceive the unwary. The diagnostic elements will differ materially in different cases, and one should not approach a patient with any conception of just what grouping of signs he will find, if he suspects there is fluid in the pleural cavity. Get all the data possible, then sum up, tapping your think-tanks meanwhile.

Too often have I, in practice, seen cases in which there was pus, or even serum alone, in the pleural cavity, treated for long periods of time for ordinary phthisis pulmonalis, not to know that the physician having them in charge had been deceived as to the nature of the case, because he found the physical signs indicating the presence, as he supposed, of lung consolidation from intravesicular causes. There is a grave necessity that the general profession recognize the fact, known to every clinician of experience, that *the physical signs will lie, if not correctly interpreted*. Correctly interpreted, they will not lie. The fluid was there, as a pleuro-pulmonary or chest-wall opening told later on. All these mis-diagnosed cases might have been saved by different therapeutic management, or by surgery.

In this class of cases there is nearly always in the history or the present symptoms something that will suggest to the careful observer that the case is not one of consumption, notwithstanding the very variable symptomatology of that disease. There is too much sweating for the amount of fever, the patient has made downward progress too slowly for the amount of consolidation discovered, there is too little or no expectoration, there is too little loss of flesh for the extent of the physical signs, or there is a history (in cases where the fluid has broken through the lung) of the rather sudden expectoration of a large quantity of pus or serum, and a very difficult, strangling cough afterward, when before there had only been a little dry cough. Any of these factors, or others, may assist in the correct interpretation of the physical signs in these anomalous cases.

Indeed, the physical signs themselves may suggest that they are not the result of intravesicular solidification. There may be a few or no râles; the breathing, while bronchial or de-

cidedly broncho-vesicular in character, is not so high pitched as in most cases of pulmonary consolidation, or the breathing may appear drier, less ringing, less hollow than ordinarily, and it may apparently be somewhat distant from the ear, and the loud voice bronchophony may lose its nearness to the examining ear or have ægophonic modifications; but of greater value to me personally is *the disproportion between the respiratory and vocal signs and the percussion note*. While with bronchial breathing and the vocal signs of consolidation you are entitled to a dull percussion note as a natural accompaniment, you never find such marked dullness and sense of resistance over any pulmonary consolidation as you do over fluid, encysted or free, and over a solid tumor. This "meat-axe" dullness, if I may so term it, is of the greatest possible aid to me in differentiating dullness due to fluid and dullness due to any ordinary consolidation. I cannot be too insistent upon this point. More than any one factor, this disproportion between the amount of dullness and the amount of consolidation shown by the respiratory and vocal signs is valuable beyond the telling, and upon it alone I have been able to differentiate those cases of fluid within the thorax that gave rise to the ordinary everyday signs found in typical intravesicular consolidations, due to some one of the pneumonias, fibrosis or phthisis pulmonalis, etc.

The term "absolute dullness" is sometimes applied to flatness on percussion. I do not at all like this term "absolute dullness." It is misleading. I much prefer the word "flatness," to signify absence of resonance, for that is exactly what flatness on percussion means. Some of our text-books tell us that flatness is the highest-pitched percussion note with which we have to deal clinically. This statement is more than deceptive, for with absolute dullness or flatness there is no pitch, for there is no resonance whatever. Now, the note elicited by percussion over fluid (if typical) is flatness; that is to say, there is no note, there is no sound whatever from within the chest, there is no sound save that made by your fingers or instruments in the act of percussion. But the percussion over fluid is not, by any manner of means, always flat; but over the site of fluid the note is always markedly and decidedly dull when not flat; and it is to this decided dullness, almost flatness, to which I

refer when I speak of the disproportion between the percussion note and the respiratory signs. No matter what the consolidating material may be in the lung proper, unless the pleura be thickened, a tumor be present, or there be a great quantity of liquid in a pulmonary cavity very close to the chest-wall, you do not get so markedly a dull percussion note as you do over a collection of fluid in the pleural cavity. This point about percussion will assist in the diagnosis of those cases of encysted pleural effusion which require surgical intervention, and which apparently show only the signs of a localized pulmonary fibrosis. By the way, pulmonary fibrosis, secondary to an old pleurisy, with great thickening of the pleural membrane, will also show this marked dullness on percussion; but here the râles, the history and the microscopical features of the sputa will assist in the differentiation.

In children, the percussion note is not so frequently flat over fluid as it is in adults; but, on the other hand, as every clinician knows, the amount of dullness discoverable in ordinary pulmonary consolidation in children is very slight, indeed, and can, as a rule, only be elicited by carefully conducted light percussion (on account of the resiliency of the chest-walls, and the fact that, owing to this resiliency, a moderate percussion blow brings the resonance from the air-cells in the vicinity of the suspected area). Hence, a markedly dull note in a child is as significant of fluid as it is in an adult; for, while the dull note is more resonant in the child than in the adult, there still exists the disproportion between the note furnished by fluid and that furnished by ordinary intravesicular consolidations.

Bulging of the intercostal spaces, or effacement, is a sign seen in fluid accumulations in children much more frequently than in adults; and this sign, whether it occur in the young or the old, if the chest-wall be thin, over a limited area, is of much value.

While the lung in croupous pneumonia, for instance, may actually enlarge during the second stage, I have not seen bulging of the intercostal spaces in any physical condition save fluid in the pleural cavity, a filled pulmonary cavity, and in tumor.

While the discovery of fluid in the pleural cavity may, in

some special instances, be difficult, I believe that the diagnosis may be made with certainty in 98 per cent. of these apparently obscure cases, provided all the phenomena—historical, symptomatic and physical—be taken into consideration.

As to the indications for the removal of fluid from the pleural cavity I have very little to say; for, save in cases of pus, I seldom feel justified in suggesting operation. But the presence of pus is often a mere guess. This brings me to say that the differentiation of serum and pus is difficult, if not impossible, in many cases. There is certainly no difference in the physical signs presented by serum and pus; and these signs only tell you that there is fluid within, but do not tell you whether it is serum, blood or pus. Bacilli's whispered voice-sign I have found absolutely worthless as a sign differentiating serum and pus. Oedema of the chest-wall, relied upon as indicating pus, is seldom present; and when it is, it is not of itself diagnostic,—only suggestive. The height of the fever is not diagnostic; the amount of sweating is not; the amount of emaciation is not; and, consequently, if the case is in need of surgical intervention, one must not be held back because he is not sure he is dealing with pus; for if there be need for the removal of the fluid, it practically, for the time being, makes no difference whether the liquid be pus or serum. If one only wants to differentiate for the purpose of scientific diagnosis, the introduction of a big hypodermic needle may settle the question, provided he does not fail to get any fluid at all for examination, which not infrequently happens with these diagnostic punctures.

The indications for the removal of the serum in a suspected simple pleural effusion vary with the case. If the fluid is thrown out too rapidly, so that the dyspnœa is overwhelming, or if there is cyanosis, too great a displacement of the heart, too high fever, too exhausting sweats, slow disappearance of the fluid, stationary fluid, the presence of agonizing reflex intercostal neuralgia, the rapid loss of flesh, and the suspicion that the liquid may be pus, these are warrantable reasons for surgical intervention in some cases. Chronicity is perhaps the reason that presents itself most often clinically, for we know that the longer the lung is compressed the less likely is it to re-expand after the removal of the fluid by either absorption or opera-

tion. In cases which I believe to be tubercular in origin, I prefer, unless there are special contra-indications, to permit the fluid to remain as long as possible; for I think I have seen latency supervene after the occurrence of a pleural effusion, compression and enforced rest of the underlying lung having possibly something to do with the occurrence of latency. I do not believe, by any manner of means, that all cases of pleural effusion are tubercular. It is sometimes wise to tap simply because the patient is losing heart at the slow progress he is making.

When you are sure pus is present, operation is indicated; for while, clinically, cure does occasionally occur in empyema, we have no more right to expect that cure will result than that a typhoid fever perforation will cure itself.

When an opening has already occurred through the lung or chest-wall,—that is, when a pneumo-hydro or pyo-thorax is present,—I think an operation is indicated to secure better drainage and to induce healing of the fistulous opening, and also to prevent as much as possible the aspiration of the liquid into the lung. Cure occasionally results in some of these pus cases. I recall a remarkable case of this kind that recovered completely without operation. I was called to see a lady who had been treated for pneumonia for ten days, who I discovered had an empyema, a displaced heart that was organically diseased (valvular), and who was also in a profound typhoid state. She was in such a bad condition that I played for time, hoping to get her in good enough shape to justify operation, when the attending nurse, with a colossal cranium and a bonanza confidence in herself, without consulting me, thought she would massage my patient's chest, soothe her restlessness, and put her to sleep. She had often put patients to sleep by massage. She massaged. The lung perforated. With great difficulty the patient was saved from the collapse accompanying the perforation. She expectorated for three months, but by standing her nearly on her head I was able to secure a tolerable emptying of the cavity. She ultimately went to the mountains, and returned in excellent health. All that remains is a slightly dull percussion note over the whole of the affected side, and a little dry broncho-vesicular breathing in a small spot where the lung perforated.

A class of cases that should receive operative attention, but seldom do, save by accident, are those in which the fluid has been removed by absorption but the lung still remains collapsed. It is difficult to determine, in some of these old cases, whether any fluid remains or not. I recall having seen a lad with a croupous pneumonia, and an exceedingly high temperature, whom I did not see after the first time until about six weeks later, when I was called again, because he was supposed to have another attack of pneumonia. At this second visit I found what I supposed was fluid in the pleural cavity, opposite to the lung in which I had previously found pneumonia, but which was now entirely clear. There was no doubt in my mind that there was fluid present, but how long it had been there I could not determine, for the case had not been watched very closely. There were present most of the classic physical signs of fluid, flatness on percussion, absence of the vocal and respiratory sounds, and even Skoda's note and increased respiratory murmur above the site of the supposed fluid. The boy was in such bad shape physically that I would not permit the use of a general anæsthetic during the operation. The surgeon got into the cavity and found no fluid whatever. I insisted that a rib be resected, and still there was no fluid. I further insisted that he make search for liquid with his finger, fearing there might be some encysting. He moved his finger around through the opening as much as possible, and got no fluid; but he must have broken up some adhesions, for a fairly resonant percussion note became evident where before there had been flatness, and the respiratory sounds returned. The boy recovered rapidly, and now has a good pair of lungs. Had I not insisted that the surgeon thoroughly explore that pleural cavity, I firmly believe the boy would to-day be a sufferer from a fibroid lung.

As I read this case, the fluid had been absorbed and left the lung, which had been previously compressed, rolled up and bound down in such shape that it was impossible to expand, and that the breaking up of the confining adhesions was the operation he needed. I certainly think there is a future for an operation that will free adhesions in the pleura; and I do not know but that this proposed operation is far more frequently demanded after the removal of fluid by

therapeutic means than is the operation for the withdrawal of the fluid during acute and semi-chronic accumulations in the pleural cavity. I hope to hear some discussion on this point.

In hydrothorax, operation is not frequently indicated; but here there is no difficulty attending the diagnosis, even though it is very frequently a bilateral affection. The mere clinical association of the physical signs,—whether they be dullness on percussion and bronchial breathing and bronchophony, or dullness with absent respiratory murmur and absent vocal resonance and fremitus, with Bright's, cardiac disease or general dropsy from any cause,—at once suggests the nature of the difficulty within the thorax. I think paracentesis is too infrequently resorted to as a palliative measure in this class of cases.

THE CURABILITY OF DEAFNESS.

BY ROYAL S. COPELAND, A.M., M.D., ANN ARBOR, MICH.

(Read at Northwestern Ohio Homœopathic Medical Society, Toledo, December 11, 1900.)

SKEPTICISM is the word, probably, which best expresses the professional idea concerning the relief of deafness. The glitter of well-worded newspaper advertising may attract the attention of an occasional layman to some invention or nostrum “warranted to cure.” The negative results of these experiments make a total which staggers the credulity of the average medical man. Therefore, the almost universal testimony of physicians is against the relief of deafness.

It is fair to say that every physician recognizes the curability of impaired hearing due to wax impaction, but it is strangely common to see this simple cause overlooked or neglected by excellent practitioners. However, it is not loss of function from stenosis of the external canal which demands consideration. The relief of deafness from this cause is the plain duty of every observant physician.

Loss of hearing-power due to intracranial causes or to disease of the internal ear is relatively uncommon. Unfortunately, however, these structures are sometimes thought to be

involved, and the disease pronounced hopeless when more careful attention to simple means of diagnosis might have prevented so disastrous a verdict.

About the ear, even, there are some things besides the treatment of otalgia which ought to be known by every modern physician. Unless the family doctor, the friend and adviser of his patron—unless this depository of medical wisdom meet his obligation to mankind, who *can* be trusted? No one more than the writer realizes the limitations of human knowledge. No one is more conscious of his own shortcomings and egregious blunders. But any physician who has practiced medicine with his eyes open for a dozen years must have reached certain conclusions concerning his profession. If the writer, who has not the slightest right to cast a single stone, may be permitted a criticism, it is this: *The health of the human race suffers more from the neglect of common, knowable and removable causes than from obscure and complicated diseases.*

Many and many a blind man is the victim of a neglected iritis. Some physician, who could not have gained his diploma without the knowledge, has overlooked its application. Likewise, many a man is being shouted at through an ear-trumpet because, back in his babyhood, somebody neglected to tell his mother that the child's snuffles demanded attention. Who is responsible? Before High Heaven, I believe some of us will have to answer at the judgment bar for such sins of omission. We prostitute our noble profession unless we meet its every obligation; and, if there is a God in Israel, we ought to suffer for it.

In deafness, the *situs* of the disease determines its treatment. For this reason an accurate diagnosis is an absolute necessity. The public has a right to expect this at the hands of any physician. The practitioner need not go further. At this point he may tell the patient that special treatment is indicated, explain its necessity, and, if requested, direct the patient to somebody who has facilities for treating the case.

As is perfectly well known, the great majority of deaf people are hard of hearing because of catarrhal involvement of the middle ear. It would be tiresome, and it is certainly unnecessary, to relate at length the details of middle-ear deafness, but if anything new has presented, it may not be unbecoming to explain its features.

Under the old system, the Politzer bag, the Eustachian catheter and Siegle's speculum completed the armamentarium of the aurist. While these instruments are by no means excluded, they are a very small portion of the outfit of the modern specialist. Indeed, so numerous and complex are the instruments, he has to know considerable of electrical engineering to keep the apparatus in working order.

Post-nasal growths, adenoids especially, which have so much to do with interference of function of the middle ear, were formerly overlooked almost universally. To-day they are sought for in every case of deafness, in children particularly. Their removal is accomplished by a choice from many methods.

Eustachian obstruction, so common in catarrhal deafness, is accurately located by means of delicate bougies made of whale-bone or celluloid. They are passed through the Eustachian catheter, and the stricture, if any exist, is overcome by sounding, exactly as is a urethral stricture.

In old cases of chronic catarrhal inflammation of the middle ear, the tympanic membrane becomes thickened and retracted, the joints of the ossicles are stiffened, and adhesions form within the tympanic cavity. Eternal tinnitus drives the patient almost to distraction. Deafness progresses from bad to worse. The Eustachian tube may be more or less open, and the use of the Politzer bag seems a work of supererogation. In such a case what can be done to improve the hearing?

For many years the profession has utilized massage as a means of treatment in lesions of the muscular, circulatory and glandular systems. For a quarter of a century aurists have sought to apply it in the relief of tinnitus and deafness. Many devices have appeared presenting features more or less valuable. Siegle's otoscope, Delstanche's masseur and Lucæ's stemple were among the first inventions intended to move the ossicles and tympanic membrane, and thus to break up adhesions by the use of massage.

Then came the phonograph, Garey's vibrometer, the vibraphone, and other instruments depending upon the conduction to the ear of atmospheric vibration. The use of these instruments created considerable discussion in the profession, and much difference of opinion. Such progress has been made that a recent writer voices the general impression when he says:

"Any discussion of aural massage at present should be one of methods, not merit."

Unfortunately, the necessary outfit for the proper treatment of catarrhal deafness is too expensive for general use. But its value is beyond question. The "Pneumophore," as Houghton's instrument is named, has certainly done great things in the treatment of deafness. It consists of a three-way pump, controlled by an electric motor. Suction, blowing, and an alternation of suction and blowing, are the three possible actions of the instrument. The pump is connected with a stethoscope, through which its effects are produced. The rapid to and fro motion of the drumhead and ossicles produces massage, which breaks up adhesions, improves circulation, and hastens resolution.

In the judgment of the writer, the use of this device will revolutionize the treatment of deafness. It is not safe, of course, to promise cure in every case, but there are few patients suffering with middle-ear deafness who cannot be benefited by the intelligent application of this system of treatment. Physicians who have employed it for a much longer time than this writer are much more enthusiastic over its possibilities. Enough has been accomplished already to make its place secure among the certainties of otology.

With an accurate diagnosis of the *situs* of the lesion and the most improved methods of treatment, deafness can be relieved.

In recording this conclusion there has been no desire to overlook the value of the internal remedy. It has the same important sphere of application here that it has in chronic arthritis with ankylosis, or in dilatation of the stomach, when mechanical means of treatment are considered of prime importance. In the treatment of any disease the physician does himself an injustice and the patient an injury if the carefully selected internal remedy is neglected. Unfortunately, most cases of deafness demanding the attention of the physician have passed into such chronic form and taken on complications of so permanent a nature that the internal remedy alone is of little avail.

The conclusion of the whole matter, then, includes a combination, in proper proportions, of internal remedy and advanced mechanics.

There is hope for the poor victims of middle-ear involvement, and our duty to mankind is not done if we fail to inform them.

This need not be by means of the public print, but through the legitimate channels of the profession itself. We are no longer justified in pronouncing a hopeless verdict upon loss of aural function.

PARALYSIS AGITANS.

BY WILLIAM H. LYLE, M.D., PHILADELPHIA.

IN 1817 Parkinson recognized and described a disease which he termed "shaking palsy." His description of the condition remains classical; he noted that the patients presented a peculiar attitude of rigidity, a characteristic gait and station, a tremor of unusual type, and general muscular weakness. Even to-day we have no better name for the malady than Parkinson's disease.

It is a chronic affection of the nervous system, well known as a clinical entity; but still so uncertain are we as to its lesion that we are tempted to agree with Dubief, who says that "Parkinson's disease has no characteristic lesions, but, on the other hand, it is not a neurosis."

It has for an anatomical basis the lesions of cerebro-spinal senility, and which only differ from those of true senility in their early onset and greater intensity.

Etiology.—Parkinson's disease very rarely occurs in those under forty or over sixty-five years of age. Most frequently it is found at about the fiftieth year of life, and about two-thirds of all the cases are found in the male sex. It very often appears in several generations of a family, especially in those of neuropathic tendency.

The onset of the disease has been attributed to such alleged exciting causes as fear, anxiety, mental and physical exhaustion and grief. Mental shock has not seldom appeared to have precipitated a sudden attack, and traumatism is undoubtedly an occasional cause. The symptoms sometimes develop immediately after intense mental or emotional excitement.

An advanced case of Parkinson's disease presents a striking picture. The patient's attitude, as he walks with short, reluctant steps, as if following his centre of gravity, his neck ex-

tended and rigid, his body inclined forward and his elbows flexed, is in itself pathognomonic. He turns bodily and rigidly. As he sits down you notice how slowly and with what precautions he settles himself on the edge of the chair, with his body leaning forward and his hands resting on his knees. If he makes the slightest change in position, he uses the greatest caution in so doing. In short, muscular rigidity is the dominant motor phenomenon, and this causes the slowness of his movements and his peculiar attitudes and positions. A characteristic tremor may or may not be present, but the rigidity is nearly always present, even in the absence of a tremor. In some cases this rigidity invades certain parts, and these subsequently become the seat of tremor.

In connection with the rigidity, it is observed that the face is immobile, smooth and mask-like. The eyes are widely open and rarely wink. The brow frequently retains its wrinkles, which are especially noticeable when the patient attempts enforced elevation for forward vision. The eyes also appear fixed, as the result of rigidity of the eye-muscles; and so the patient, in order to change the direction of his vision, turns bodily with his neck held stiff. The face, be it noted, is always held to the middle line, the chin somewhat in advance. The muscles of the neck are always involved, giving the patient an appearance of "stiff neck." The body is bent forward, especially from the hip-joint, and, as a rule, the flexor positions predominate, although in a few cases the neck and body are bent backward.

The fingers, hands and arms, like the body, are always flexed, but the stiffness of the lower extremity is less marked, and only in advanced cases do we find the knee-sprung attitude and gait.

When our patient rises from a sitting position he frequently hesitates for a moment before advancing a step; then he starts ahead in a straight line, taking short steps as he tries to keep up with his forward leaning body. At times his motion can be arrested only by his running against some fixed object, such as the wall. In other cases there may be no actual tendency to fall forward (propulsion); but if the body be started backward or sideways by a sudden push, that direction is maintained for few or many steps, this phenomenon being termed latero-

pulsion or retropulsion. This may occur when the patient gets up, or when he attempts to stop while advancing.

Fränkel believes that the peculiar rigidity of expression in cases of paralysis agitans may be due to alterations in the skin, and is not, therefore, referable to lesions in the nervous system. By means of a calliper he has measured the thickness of folds of the skin, and, dividing the results thus obtained by two, he reckons the thickness of the skin itself. In one case in which the patient had symptoms more pronounced on the right side, it was found that the skin of that side was as much as 2 mm. thicker than the skin on the other side. In another case, in which these conditions were reversed, the difference was in some places as great as 5 mm. Moreover, as compared with normal persons, the skin all over the body was increased in thickness. This stiffening and thickening of the skin may become so extreme that it is impossible to obtain a fold, as occurred in the case of a man forty-one years of age, who had suffered from the disease for twenty-one years.

Another method employed was that of taking the circumference of both limbs, and this yielded similar evidence of thickening of the integument.

Fränkel concludes, therefore, that in paralysis agitans distinct pathologic alterations occur in the skin, although it would appear that no microscopic examinations have been made. He looks upon the peculiar cutaneous phenomena, *e.g.*, the subjective sensations of heat, etc., as paræsthetic phenomena, produced by the changes in the skin, and he believes that the vasomotor symptoms are also produced locally.

Fränkel is also of the opinion that the lesion of paralysis agitans is not in the nervous system at all, but in the muscles. He bases his opinion largely upon the presence of rigidity and the utter absence of distinct lesions in the nervous system.

The tremor of paralysis agitans usually commences in one hand and arm, and then it involves the lower extremity of the same side, and later appears in the opposite arm, and finally the opposite leg. It is frequently more marked on one side than on the other, but it may be bilateral from the start. As a rule, it remains unilateral for years before showing a tendency to become bilateral. Frequently we find the rigidity well advanced and of long standing before the slightest tremor ap-

pears. Especially is this true of the hands and arms, where it generally appears first and is most developed. The characteristic tremor is rhythmical, flexion and extension of the fingers at the metacarpal joints alternating. Frequently the tremor is limited to the thumb and index-finger, or especially affects the interossei, giving rise to a motion which suggests the rolling of pills between the fingers. At times, movements of pronation and supination are detected, there may be alternate flexion and extension of the wrists, and, in rare cases, the arms and shoulders are affected.

The tremor of the foot is at the ankle, causing a clonus-like movement of the foot. A true foot-clonus is never encountered, however. The toes very seldom become involved, but the patients often complain of cramping of the toes.

The muscles of the shoulders and dorsum of the body are least affected, and the abdominal muscles apparently escape entirely.

A rhythmic nodding, rotation or shaking movement of the head, seen even when the patient is in a recumbent position, is present, but this is often due to movements communicated to it from other members. The striking peculiarity of the tremor wherever seen is that it occurs usually while the member is at rest, ceases during sleep, and, as a rule, disappears momentarily when the patient attempts voluntary motion.

The tremor is a slow one, presenting from four to eight oscillations in a second as long as it remains confined to the small muscles, and becoming even slower when it involves the large muscles.

Sensory Disturbances.—While cutaneous sensibility is always normal, sensory symptoms are often complained of. Particularly common is a sensation of heat or burning all over the body, and, because of this, these patients often expose themselves to cold air, especially while in bed. This symptom appears to indicate a vaso-motor paralysis, as the result of which the internal temperature is normal, while that of the periphery is slightly elevated. As a rule, the mind remains clear until very late in the disease, when, as a result of senility, there is apt to be weakness of memory and a decided loss of mental power.

In a recent number of the *Philadelphia Medical Journal*,

Stewart, reviewing thirty-eight cases of paralysis agitans, offers some interesting observations. Seventeen of his cases occurred in men and eleven in women, and he found that in over 82 per cent. the disease commenced after the age of forty-two years. The youngest patient was twenty-three, the oldest seventy-three years of age at the beginning of the disease. Stiffness was the first symptom noted, the tremor developing later in one-half of the cases. The symptoms were unilateral in character in most of the cases, the left side being affected in a majority of them.

The side first attacked invariably remained more severely affected than the other side. The upper extremity was affected below the lower in eighteen of the twenty-eight cases. Dull aching pains in the affected limbs, together with stiffness and weakness, often antedated the rigidity and tremor by several months. The "starched" expression of the face persists, with scarcely any play of the facial muscles when the patient talks. This condition may be unilateral. In six cases tremor of the face developed, especially about the lips, and antero-posterior tremor of the tongue was associated.

A majority of the patients complained of the toes of one foot occasionally becoming strongly flexed and curled up under the sole in a cramp-like fashion, which caused difficulty in walking.

Diagnosis.—Until the time of Charcot a differentiation between paralysis agitans and disseminated sclerosis was not made.

That astute observer called attention to the fact that in the latter disease the patient, while able to carry heavy weights, is prevented from performing any of the finer voluntary movements of the hands. For instance, if he is asked to drink from a tumbler of water, and attempts to raise a full glass to his lips, his tremor increases until very little water is left in the vessel. In cases of paralysis agitans, on the other hand, the tremor ceases when the attempt at voluntary motion is made. In further examination we find a still greater distinction, for in disseminated sclerosis an ankle-clonus is present. Moreover, if the eyes are examined, nystagmus is usually found to be present, and if we listen to his speech we find it "scanning" in character. In addition, paralysis agitans is rare before mid-

dle life, while disseminated sclerosis is common in young adults, the majority of cases beginning between the ages of twenty and forty. The reflexes are exaggerated in disseminated sclerosis.

The course of the disease is essentially chronic and progressive in character, extending over a period of from ten to forty years. In extreme cases the patients become almost helpless, but finally die from some intercurrent disease. The prognosis is extremely unfavorable. All authorities agree that the disease is absolutely incurable. There may, however, be remissions in the course.

Treatment.—The fact that pathologists generally agree in attributing the phenomena of Parkinson's disease to conditions sequential to arterio-sclerosis suggests that treatment be directed primarily to combating that process. Warm baths, given at bedtime for a period of fifteen to thirty minutes, are of unquestionable value, because of their effect on the general circulation. Cold sponge baths, rapidly applied on arising in the morning, undoubtedly possess a decided tonic influence. In addition, remedies applicable to sclerotic processes, such as aurum, plumbum and phosphorus, may be prescribed.

For the control of the tremor a number of remedies are prescribed; almost all, be it noted, are derived from plants of the solanaceæ family. For the past two years we have made extensive use of atropine in the neurological department of the Hahnemann Hospital dispensary, administering one-grain tablets of the third decimal trituration every three hours. Our results have been quite satisfactory. Hyoscine hydrobrom., in doses of $\frac{1}{100}$ or $\frac{1}{60}$ of a grain three times a day, is extensively used and highly praised by a number of excellent clinicians.

Dr. Allen Starr, of New York, expresses a preference for hyoscyamine, giving $\frac{1}{100}$ of a grain three times a day, and is quite enthusiastic as to its results. In the use of all these remedies some care is necessary lest an excessive dose lead to disagreeable dryness of the throat, to which many patients prefer the tremor.

PREGNANCY AND CHILDBIRTH AMONG THE ANCIENT SCANDINAVIANS.

BY FRANK H. PRITCHARD, M.D., MONROEVILLE, OHIO.

AMONGST the ancient and robust Northmen childbirth probably was, in general, rapid and easy, as usually holds true in nations living near to Nature. That this was not always so, and that labor was at times hard enough, is seen from the ancient writings, for women were said to have died immediately after childbirth or in childbed.

The Icelandic chieftain, Valbrand, had a daughter by name of Signy who was surprised by the throes of labor while on a visit at her brother's; she had a very difficult labor, and died soon afterwards. The most ancient sagas mention various means, incantations, formulas, etc., which were to be used to render childbirth easier. The amazon, Skjoldmoe, or shield-maid, Sigrdriva, thus taught Sigurd Favnesbane, besides several other powerful "runes," also "Bjergruner," to deliver women in childbirth—leysa kind fra konom—to loosen a child from a woman. According to the *Fatnismaal* the *Nornes* are those on which one should call for help. In the *Edda*, in that poem entitled the *Oddrunar-graatr*, it is related that Borgny long lay in the hard throes of childbirth, until finally King Atles' sister, Oddrun, went to her, "to sit at her knees," and by her mystic chants (witch-songs) brought about Borgny's delivery.

Oddrun
gecc mild fyr kne
meyio at sitia
rict gol Oddrun
rammt gol Oddrun.
(Oddrun tenderly
went to sit at my knees.
Powerfully chanted Oddrun,
Mightily sang Oddrun.)

In the *Havamaal* a chant is given whereby one may obtain the "white-armed" woman's favor.

When Borgny thanked Oddrun and wished her Frigga's and Freya's aid if she should ever be in such straits, she answered her that she had not helped her because she had deserved it but

on account of her own sad fate, for she as well as Borgny had become pregnant outside of wedlock. She had made a vow to help at any time when noble families should "change heritage" (in births).

A similar tale is told of the birth of Saint Olaf (985 A.D.). His mother, Aasta, who was living with her father, Gudbrand Kula, long had lain in labor without being able to be delivered. "Litlu Sidhar tok Aasta jodhsott (child-sickness) ok var thungligen haldin."

Her husband's foster-brother, Rane den vidfoerle, who had just come home, placed a belt about her which he, directed in a dream, had found in the grave of King Olaf geirstadaalfs; shortly after she "became easier" (was delivered). It is said that the Laplanders to-day are accustomed to lay weapons, that have been found buried in the earth, alongside of parturient women to hasten labor.

The ancient Britons are said to have had girdles to aid labor. They were generally used, and were some of the treasures of the kings. They were covered with mystic signs and were bound round the woman in labor, with certain ceremonies. Fingal's daughter, in one of Ossian's poems, in his behalf, in a compact promised amongst other things . . . "hundred girdles shall also be thine, to bind high-bosomed maids. The friends of the births of heroes. The cure of the sons of toil." This custom, said to date back to the times of the Druids, was continued until recent times in the north of Scotland. This corresponds to the use of relics and the calling on of saints of the Middle Ages. The church in the early days was careful to take up many of the holidays and customs of the heathen Saxons and Norse, but to give them a Christian name at the same time, so that the change in their ways would not apparently be so great after all.

In Denmark, during difficult labors, it was the habit of the people to pray as follows :

Jomfru Maria laan mig Noglerne dine
At jeg kan aabne Laenderne mine.
(Virgin Mary, lend me thy keys,
That I may open loins.)

At other places in the Norse literature mention is made of

binding slips of paper about the woman's neck on which had been written pious sayings from the Bible. What all was not done in those days? The celebrated Italian physician, Pietro Bayro, would have a woman in difficult labor take a bath in an infusion of herbs and have whispered into her ear the following words: "Su, ca midur;" "et statim peperit filium sanum et ipsa, Deo favente, sana facta est," he says.

This ancient idea of opening, expressed in the prayer, is, without doubt, immediately connected with the old Greek thought that the pelvis and the parturient canal are by nature too narrow and must be dilated during childbirth, opened as it were. And away down towards our times it was the custom to undertake a more or less distressing opening of the "locks of the womb." Closely connected is the idea, which is very widely diffused and probably transmitted from the Greeks and Romans, that there must be no knots nor unloosened bands on the parturient woman, nor on any one about her. Again, no one near the patient should sit with his legs crossed, for that would delay labor. This notion is still held in some parts of Norway.

In a Scotch song—Walter Scott, "Minstrelsy of the Scottish Border," ii., p. 32,—a son by cunning got his mother to reveal the witchcraft by which she had "bound his wife's belly," so that she could not bring forth.

"O wha has loosed the nine witch knots
That were amang the ladye's locks?
And wha's ta'en out the caims o' care
That were amang that ladye's hair?

* * * * *

And wha has loosed her left foot shee
And let that lady lighter be?"

"Lighter be" is a true old Norse expression, and signifies to be delivered.

In the folk-tales sudden deaths after labor are mentioned with striking frequency, which points to their not being so infrequent in those days. Nyerup in his collection of tales gives one:

"Stolt Hellelille ganger i stenstuen ind
To soenner saa monne hun foede.

* * * * *

De tvinged hendes liv tildoede."
 (Proud Hellelille went into the stone room
 Two sons she is said to have borne.
 * * * * *
 They forced her body down to death).

Grundtvig, in another folk-tale, says that "proud Ingelild died after having borne a son which was laid in the grave on her breast." In still another he relates that the daughter of the Danish king died in the green city of Lund (in Sweden), where she had given birth to two sons, who were buried with her. A barbaric but very peculiar feature is noticed in many of these tales: if the mother died, but the infant survived, it would be buried alive with her. Grundtvig, in the tale Froeken Dagmar, mentions this horrible custom.

"Aller forglöymer eg den kvie.
 Dei tvo smaa baani laag mae doee mo'ers sie.
 * * * * *
 So hoerde eg dei smaa baani i jori lef."
 (Never shall I forget the cry
 Of the two little children as they lay on their dead mother's breast.
 * * * * *
 Thus I heard them in the earth alive.)

"Han lagde Roselille der i med liden troest
 Og begge de smaa levend', la han ved hver sit broest."
 (He laid Roselille in there (the grave) with little consolation,
 And both the little living ones, one on each breast.)

Liden Kir-ten lagdes i jorden saa tyst
 Nilaus la'en soen paa huert et broest.
 (Little Kirsten was laid in the earth so silent
 Nicolaus laid a son on each breast.)

It is questionable whether this was a general custom; rather was it handed down in the folk-tales from prehistoric ages. At times such a sacrifice was made in the hope of freeing the survivors from sin or sickness. In olden times it was a general belief in the North that a building, or even whole regions, might be protected against sickness and all kinds of misfortune by burying a human being or an animal, preferably a lamb, alive. This was done in several districts in Sweden and Denmark while the Black Death raged, in the fourteenth century. And, indeed, as late as towards the end of the year 1603 a woman in Ringkjoebing, in Denmark, buried one of her chil-

dren alive in order to stop the plague. As late as 1830 a horse was interred alive in Bohuslen, Norway, to put an end to an epidemic among horses.

Henrik Harpestreng, who lived in the thirteenth century, in his work on medicine, mentions several remedies used to hasten labor which were employed in the North during the later Middle Ages. Amongst others he names several precious stones which, from the earliest times, have been accredited with powerful and mysterious virtues. For example, "the agate is good for childbirth . . . and shows whether a maid be a virgin or not" (a valuable stone).

The loadstone was supposed to be gifted with power "to lighten childbirth." Harpestreng did not know this, but he attributed to it greater powers. "If one would prove if one's wife be true, let him place a loadstone under her pillow; if she become affectionate ('make friendly motions'), then she is true; hauer hun hoor goerth; tha lataer hun illae i syfnae." Haakon Galin's son, Knut Jarl, who lived at the beginning of the thirteenth century, was held to have a special insight into the mysterious virtues of stones. In a much later work, the Swedish Liten Laekiare-book, which was ascribed to the Archbishop Olaus Martinus, who lived about 1600, he advised in difficult labors that the patient hold a loadstone in her hand. Other stones, as the oerne-sten and the lausnarsten, were used for the same purpose in Iceland, the latter to be dissolved in French wine and drunk. The so-called "thunder-stones," meteorites, were said by the pious and credible old Bishop Pöntoppidan to be useful in difficult labors. Pöntoppidan was he who first described the "kraken," the huge cuttle-fish a mile or so across, that made the ocean the fear of mariners before the time of Columbus.

"Whenever a woman be in the throes of childbirth, pour beer on a thunder-stone and give it to the woman to drink; thus the child will be loosened." Pöntoppidan also solemnly stated that help may be given a woman suffering in childbirth by binding a cast-off snake-skin about her abdomen. In Nordhordland, in such difficult cases it is the custom to stroke the parturient's abdomen with the right paw of a bear, "which always helps." A number of remedies are given by Harpestreng. Among others, nasturtium, "wraeker ut af mothaer

doet barn." "If she smell of the flowers of Maroclus, then she will cast her child," he also says.

Olaus Martinus speaks highly, "if a woman be pained with child," of letting her drink of an infusion of nettle-seeds and tying coral beads about her thighs. Pears must be removed from the house if the patient wish it, "for they hinder by their odor." The old Icelandic Leech-books, if a woman bear children with difficulty, advised to let her drink dog's milk mixed with honey or human milk, to eat the spleen of a horse stirred up with water, to drink ox-gall in wine, to inhale the fumes of burnt horse-dung or sulphur. And, finally, if these measures do not help, to drink the water in which two eggs have been boiled; "this must aid, with God's help, for the egg itself is a birth, and therefore the water must give strength to bring forth."

Several remedies are noticed for coldness on the part of the opposite sex, to cool down ardor, to test whether a woman be a maid or not, to hasten or prevent conception, etc. The latter measure I shall mention, for it might be tried: "Let the woman wear on her breast iron-filings, in a bag made of the hide of a deer."

To bring about a good understanding amongst married couples the husband should wear over his heart the heart of a male raven, and his wife that of the female bird. In Henrik Smid's Danish Leech-book, published in the sixteenth century, he advises, in difficult labors, letting the woman blow or sneeze while she sits over a vessel in which myrrh, castoreum, galbanum, or dove's or hawk's dung is burned. Pliny states that "penna vulturina subiecta pedibus adiuvat parturientes." This is still used, in Wuertenberg, in childbirth.

Whether the wives of the old Norsemen were generally addicted to the habit of bringing about abortions cannot be decided from the sagas, though it must now and then have been done, as the following story, probably an example, shows:

"After a visit which the King Harald Haardraade had made at the castle of a mighty chieftain, Halldor, the latter's daughter, Ingeborg, fell ill, for her belly began to swell. When Harald, who, like all the Germanic kings and chieftains, was thought to have a sort of knowledge of medicine, heard this, he declared that she had swallowed a snake, and at once journeyed

to her house to treat her. After having had the maid go for some time without water, he poured a few drops into her mouth. The snake, thirsty after so long waiting, stuck his head out, and was seized by the king and drawn out. Thereafter the girl recovered. Some time later the king interfered in a match about to be made for her, and sent her to a convent in some foreign country." Among the South German tribes abortions do not seem to have been so very rare, for they had each their laws against the practice. Possibly they learned this later of the Romans, who were terribly given to this crime. Even from Sulla's time an attempt was made to stop it, but the *lex Cornelia* helped but little. . . . "Si mulier visceribus suis vim intulisse, quo partum abigeret, constiterit: eam in exilium Praeses provinciae exiget."

The German law probably used this as a model:

"Si quis mulier, qui potionem dederit ut avorsum faceret: si ancilla est, 200 flagella suscipiat; et si ingenua, careat libertatem.

"Si quis mulier coitu (ictu) quolibet avorsum fecerit: si mulier mortua fuerit, tamquam homicida teneatur.

"Si vero infantem in ventre matris suae occiderit aut ante quod nomen habeat cui fuerit adprobatum, 4000 dinarios, qui faciunt solidos 100, culpabilis iudicetur."

Amongst the Frisians this practice went unpunished, for amongst those mentioned "quo sine compositione . . . occidi possunt . . . et infans ab utero sublatus et enecatus a matre.

ACUTE INTESTINAL OBSTRUCTION SUCCESSFULLY TREATED WITH QUICKSILVER.—McKean Harvison (London) records two cases of apparent intestinal obstruction, in each of which, operation being declined, he gave as a heroic remedy a half pound of quicksilver at a dose. In both cases this was followed by improvement within 24 hours. In neither of the two cases was there the slightest symptom of mercurialism, nor did the drug produce any increased abdominal pain. The author inclines to regard at least one of the cases as volvulus, and in that case the action of the quicksilver, by its weight and fluidity, may readily be understood. In the absence of exploration or of necropsy, the exact diagnosis must, unfortunately, remain unsettled.—*Brit. Med. Journal*, April 26, 1902.

FRESH- VERSUS DRY-PLANT TINCTURES.

BY F. A. BOERICKE, M.D., PHILADELPHIA, PA.

I WOULD like to make a few observations in reply to an article in your last issue written by Edward A. Bender, Ph.G. It is very evident from the article that Mr. Bender is an old-school druggist, and, moreover, has not made himself acquainted with the principles on which the homœopathic school is founded. Hahnemann states in his *Organon*, concerning drugs: "In order to perform a cure, it is necessary that drugs should possess the power of producing in the human body an artificial disease *most similar to that which is to be cured.*" It is a fact that fresh-plant tinctures contain in solution certain volatile principles which do not exist in tinctures made from the dry plant. These volatile principles have some physiological action, and will more or less modify the totality of the symptoms produced in the proving of the drug, and hence in the removing of them in the sick. This fact is of the greatest importance for the physician who administers medicines for their homœopathic curative effect, and is in itself sufficient to condemn anything that will interfere with the similimum of such medicines.

It is therefore absurd to assume that the dry-plant tinctures can fill the place in our school of our fresh-plant tinctures and fully serve the same purpose.

Dry-plant tinctures may be useful where it is desirable to administer a drug for its physiological action only, but even in such cases it is likely that a fresh-plant tincture is to be preferred to that made from the dry plant direct, or from the fluid extract, which is most frequently used as a basis by the dry-plant champions.

We find the statement made, in the latest (1900) edition of King's "American Dispensatory:" "While gelsemium is one of our best remedies, yet like iris, phytolacca, and other plants, it suffers from worthless representatives on the market. These preparations, made from old, dried material, will fail to fulfill the expectations of him who administers them for the specific effect."

Concerning *rhus toxicodendron* we read, in the latest "U. S. Dispensatory:" "The best preparation would undoubtedly be a concentrated alcoholic tincture, made from the green drug." See also "Materia Medica, Pharmacy and Therapeutics," by S. O. L. Potter. In this latter work we also read, concerning *pulsatilla*: "The imported German homœopathic tincture is an efficient preparation; but tinctures or fluid extracts made from the imported dried plant are not trustworthy." Also in the same work, concerning *digitalis*: "Much of the leaf found in our shops is of very poor quality, a large portion being inert. . . . When the leaves are imperfectly dried, a process of decomposition sets in which destroys the active principle, and may produce new poisonous ones. . . . Digitalis is one of the most unreliable drugs, in respect to physiological activity of any particular sample or preparation." This uncertainty does not exist in the fresh-plant tincture; besides, fresh *digitalis* contains a volatile oil and a volatile acid, both of which are lost in drying. In Hare's "Practical Therapeutics" we read, under *Bryonia*, "The so-called mother tincture of the homœopaths is, perhaps, the best preparation for ordinary use." *Thuja* owes part of its efficiency to a volatile oil, and, therefore, even the old school prepares the tincture from the fresh plant.

This evidence, without adding much that could be given from homœopathic authorities, is sufficient to leave no doubt as to the fact that dry-plant tinctures cannot fill the place of a properly made fresh-plant tincture.

OBSTETRICS AMONG SOME PRIMITIVE WOMEN.

BY BERTRAND K. WILBUR, M.D., ARDMORE, PA.

(Read before the W. B. Van Lennep Clinical Club.)

THE prevalent idea among professional men as well as among people in general is that the Indian mothers bring forth their children with about the same degree of ease as do most animals, and suffer as few bad results from this violent mechanical ordeal. I was told, by a friend, of an Indian woman who rode into Walla Walla, Washington, where he then lived. Arriving at a vacant lot, she dismounted, and, squatting on the ground,

arranged her blanket carefully about her, presently arising with a newborn infant in her arms. After this, she carelessly mounted her horse and rode away. Such is certainly the popular idea of how easily this act is accomplished; but such stories must be taken with the proverbial salt. Certainly such are not the conditions among the women of southeastern Alaska. Whether or not the plains Indians escape the pains and perils of parturition to a greater extent than the Alaskans I cannot say, but it is extremely doubtful. Some description of the average labor of these Alaskans, with some of their native customs affecting puberty, pregnancy and parturition, with the frequent unfortunate after-effects, may claim your attention this evening. It will, I trust, make our subject the clearer, to recall to our minds something of the life of these Alaskan women and their probable ethnology. Those spoken of here belong to the Khlingit tribe, which lives along the Alaskan coast from the Aleutian Islands to British Columbia. They are not Esquimaux, who live farther north, nor are they Aleuts, who live between the former and latter tribes. Neither are they very much like the plains Indians. Their descent is obscure, but I fully believe, after seven years among them, that they are descended from an Asiatic race, probably Japanese. The women are not degraded slaves, as among the plains Indians, nor do they perform most of the work. On the contrary, the burden of living is about equally divided between husband and wife, their life involving a large amount of physical labor for both, and not a little exposure to dampness, cold and hardship for the woman. They are experts at canoeing, in tanning skins, weaving baskets, and in needle- and bead-work. In their native state they are moral, true wives, and good mothers as far as they know how to be. Marriages are arranged by the relations, generally uncles and aunts, and the man gives presents of blankets for his bride. If, after a time, the young people do not find themselves congenial, then the wife returns to her parents and the husband's presents are returned. Infidelity on the part of the wife is almost unknown, and when it does occur, it is sometimes punished by death.

Polygamy was not and is not uncommon. These customs have now largely given place to legal marriage and divorce; and, unfortunately, adultery is not uncommon—thanks to the graceless white man, who leaves God, the Sabbath and a large

part of his decency somewhere between the east and the Alaska border.

A curious custom which is still quite generally practiced is this: when a man dies, a relative "is in line" to marry his widow. The succession is complicated, but it descends from a man to his nephew; and, as a result, a mere boy is often married to a woman many years his senior. They say it's a good thing for the boy; but such unions are generally fruitless, or with weak and puny offspring. But sometimes a boy who has been busily sowing wild oats, and it's a very bad brand they sow in Alaska, will seek a union with an aged woman, because, forsooth, "She make me do right now!"

When a girl arrived at or was near to the age of puberty, she was generally shut up in a very small room in her father's house, attended only by a female slave. Here she was kept continuously until her menstrual periods were regularly established. As a mother neared her full time, the husband built a rude and often very flimsy hut near their house. Food and water were placed in it, and at the first sign of labor the woman entered it, willingly or otherwise, sometimes attended by a so-called midwife, sometimes alone, and here the child was born. It made no difference if the weather was freezing cold, or as terribly dismal and rainy as Alaskan weather can be, still she stayed there; and it is not strange that the death-rate of mothers and babies was very high. Both of these customs have been largely abandoned, though the latter one of forcing the mother to go into a hut has been practiced at Sitka within four or five years—in one case, at least, with fatal results.

Mother and babe stayed in the hut until the lochia ceased, when she was considered clean enough to return to her home. No doubt this custom arose in part, at least, from the fact that the large house had but one room, and six or more families lived in that. Hence there was no chance for privacy.

The midwives palpate the abdomen, but rarely, if indeed ever, examine per vaginam.

Of course, any delay or accident during delivery was attributed to evil spirits or witchcraft, and the Indian doctor was called in for his incantations. It is not probable that he ever actually visited the women in labor, but held his devil-worship near their huts.

These women are generally supplied with broad pelvices,

long vaginas, and abdominal walls neither weakened nor compressed by corsets.

They choose by preference a squatting, nearly upright position for delivery. The position is unique, and one calculated to bring the muscles into the best possible position for voluntary assistance. Since the use of beds has become quite general, the arrangement is a modification of the old native plan, where the woman was placed on the ground. If the bed has springs, they are removed, and boards are put in their place. At one side of the bed a hole is cut through the boards, and a box placed beneath the hole. This is well lined with moss, and large enough to hold the newborn infant. In front of the box, at the side of the bed, is a strong pole, four or five feet long, firmly fastened in an upright position. The woman places herself over the box and grasps the pole on a level with, or a little above, her head. Two other women sit, one on either side of her hips, and support and press against her knees. During pains, the woman in labor pulls upon the pole and presses against the side of the bed, thus having four fixed points for counter-pressure, while the knees, more or less firmly held by the two helpers, add still more to the effective work of the voluntary muscles. In such a position, every ounce of muscular pressure is brought into its best use; but it can readily be seen how exhausting such a posture is, and how severe is the strain on the perinæum. It is hardly necessary to add that the work of the medical attendant is anything but agreeable under such conditions. It is almost impossible to make an examination, abdominal or vaginal. The native idea seems to be that to tie every voluntary muscle into knots of greatest tension, from beginning to end, is the best method, and it is common to find women in the first stages of labor making really violent voluntary expulsive efforts. There is very frequently failure of the membranes to rupture spontaneously. It has been the rule, rather than the exception, to find the membranes very tough and resisting.

While the stage of dilatation is shorter than with the average white woman, it is not as markedly so as is the stage of expulsion. In multipara this is exceedingly rapid, as a rule. The pains come at very short intervals, and the vaginal and perineal dilatation is rapid, and seemingly with much less suffering than among white women. In one instance, after the amniotic

fluid escaped, one pain, lasting perhaps two minutes, accomplished delivery. Very frequently, three to eight or ten contractions gave birth. It was noticeable that, as the child descended and was fairly past the os uteri, the woman seemed to be carried away with an intense desire to expel, and was unable to lessen or cease her efforts until the pressure was relieved. We notice something of this among white women, but they continue the effort a time, and then relax and rest. To these Alaskans it seemed impossible, generally, to relax. Pain follows pain in rapid succession until the child is born.

After delivery, even very generally at the present time, the woman or her attendant takes very great pains to hold on to the severed umbilical cord. It must never be let slip, for if it should get back into the vagina the worst results would follow. Just what would happen they do not seem to know, but it is most probable that traction on the cord was the usual way of delivering an indolent placenta. Hence the loss of the cord would generally mean a very great delay in its delivery, or quite possibly septicæmia and death. Primiparas generally have slower labors and evidence more suffering, but they are more easy and rapid than the first delivery of the average white woman.

We might expect that the usual well-nigh continuous efforts to expel the child in the second stage would leave the uterus exhausted and unable to expel the placenta, and such is very frequently the case. This condition occurs in at least three-fourths of the cases observed. How long the atony would last could not be observed, for the natives insist on almost instant delivery. However, cases have been seen which gave a history of delivery six or eight hours previously, with the placenta still retained. In nearly all these cases the separation had taken place, and the placenta lay just within the os.

Hæmorrhage was rare, and a firm, contracted uterus after placental delivery was the rule.

But it will be a surprise to most of us to know that laceration of the cervix and perinæum was of frequent occurrence. In gynæcological work it was evident that these accidents had been common among these women for years. Complete laceration was rare. Personally I never saw a case; but very deep, incomplete tears were the rule. It seems more than probable that the nearly upright position already referred to has much

to do with this accident. It is interesting to note that, while the perinaeum is so often injured, and nearly always unrepaired, any tendency to descent of the womb is unknown.

Immediately after delivery of the placenta, the native women attendants, as quickly as they can, adjust the binder. And such a binder! I often wondered what the consequences would be should one of our women of fashion be approached with such an instrument of torture. The binder is long enough to encircle the patient, and varies from four or five inches wide in back to eight or ten in front. It is made of two thicknesses of cloth—the outer one generally a dark woolen, with the inner one a light calico. Between these two, pieces of thin wood are placed, held securely by stitching the two bands of cloth together. These pieces are so placed as to make pressure on the abdominal viscera, and especially on the uterus. The whole contrivance is laced up in the back. It is as though the woman was encircled by a section cut from a barrel. This is almost invariably worn and kept on an indefinite time, but not after the woman leaves her bed. The thing looks barbarous, and we would expect it to cause abdominal atrophy and retroflexion. As far as I could see, it produced no bad effects. The lying-in period varied, but an ordinary case would be up and about as soon as the lochia ceased, which it generally did a day or two earlier than among white women.

During my stay in Alaska I never heard of the delivery of twins, either during that time or before it, in Sitka or elsewhere. Dystocia occurs occasionally. In about 250 or 300 cases there was one shoulder presentation. The most common presentation is the usual one among whites, with occasionally a breech or face.

Subinvolution, cervical endometritis and metritis are common. Gonorrhœal infection is very general, and syphilis a close second. Some of the neglected syphilitic cases are most terrible; but this does not properly come under the province of this paper, and is mentioned only because here lies the most probable cause of the frequent cases of sterility.

The period of lactation is extended to two or three years. The breasts are long and pendulous, and the supply of milk generally abundant. These women do not find lactation a preventive of conception, and I have known cases in which the mother was still nursing the former child when the new

one was born. As a rule, however, the child is weaned when pregnancy again ensues.

It is to be regretted that many statements of comparison in this paper are so general, but it is not the rule to call in the white doctor,—Naukeish or Ko-nauke-sate, in the Khlingit tongue,—unless labor is delayed or some accident occurs. Midwives officiate, antiseptics are unused, but, as a rule, all goes well. When a doctor is called, therefore, he sees but a fragment of a case, and most often one that has gone wrong; and the previous history is always unreliable, because of the tendency of natives to exaggerate their symptoms in the hope of getting *stronger* medicine. Hence conclusions must be built up on these fragments, taken together with the fewer other cases he has watched throughout.

Before concluding, I beg leave to relate a case occurring in Sitka of a white woman whose entire labor, ending in the delivery of a healthy boy, was shorter than that of any native woman seen. The woman was an Eastern woman, of good breeding, unaccustomed to hardship, and not of the laboring class. This was her second pregnancy. She had not been particularly robust, though not in poor health. She had expected delivery for a month previous to her actual confinement, with frequent quite severe pains, some mucus discharge, and an os dilated to the size of a dollar. But though on the verge of labor all this time, nothing further developed.

After lunch one day, to which she sat down in her usual health, she began to have pains which continued and increased for one hour and a half, when a 12-pound baby was born. The physical suffering in this case, however, was very severe.

The foregoing statements show, I believe:

1. That all Indian women do not bear children with little pain, and without physical injury to the soft parts.
2. That, as compared with white women, the Sitkan women have a more speedy and less painful labor.
3. That the nearly upright position dictated by Nature, while assisting rapid delivery, greatly adds to the danger of laceration.
4. That a firm, hard binder apparently produces no bad effects.
5. That diseases of the genital tract, due to gestation and parturition, are very common in some of the primitive races.

EDITORIAL.

STILL SOME HOPE FOR HOMŒOPATHY.

IN glancing through *American Medicine* for May 10th, our attention was attracted by the title of a paper which promised something of interest: "Sectarian Medicine, its Etiology and Treatment," by A. E. P. Rockwell, M.D., of Worcester, Mass.

As a result of the reading, in addition to a feeling of some indignation at certain points in the article, to which we shall give our attention below, we were put into a state of doubt and perplexity as to the position occupied by the writer. By the use of "we," in certain connections, he evidently sought to identify himself with the homœopaths; while, on the other hand, by the use of the word "non-sectarian," applied to the "regular" school and its institutions, he placed himself decidedly on their side. He was so upright, he leaned backward. We had recourse to the obese collection of Polk-lore (medical), and found the name, presumably representing the individual in question, as having graduated not quite three years ago, and furnished neither with an R. nor an H. after it to indicate his preference or allegiance. We are probably supposed to supply a big, big P.—physician, pure and simple.

We do not consider medical infancy a bar to the expression of opinions, but only as a sort of discount on their value. Prodiges do occasionally present themselves in all walks of life. Not longer ago than yesterday we read of such an one, in the person of a three-year-old youngster, who could spell "assassination" without winking, and any phonetic word without preparation; and some time back a female prodigy, aged six months, was reported as having begun to exercise the prerogative of her sex, and, amongst other things, to have prophesied a famine for Kansas at the end of six years. Such *lusus naturæ* do, therefore, occur, as we see; but by their fruits ye shall know them. In the case before us, however, we have no such self-confessed

prodigy, and we fail to detect any striking evidences of unusual precocity; the work needs revision.

Let us see whether, by any process of reasoning, the word "non-sectarian" can be applied, as is here done, to the so-called regular school. The writer speaks of "non-sectarian medical schools," "societies of non-sectarian practice," and "non-sectarian investigators."

The University of Pennsylvania can be regarded as a pretty fair type of their medical schools, and the little incident commented upon in the last number of this journal shows very plainly, we think, their non-sectarian character. A more striking example of petty, bigoted sectarianism could hardly have been manufactured to order, and we know that the institution has shown itself capable of *marshall*-ing a host of similar instances no less emphatic.

Have their societies shown themselves any less sectarian? Their past conduct towards those of their own membership who claimed to have what they all professed to be seeking—an established principle in therapeutics—does not go to prove it. In how few, at the present time, is homœopathy ever mentioned except to be ridiculed or denounced. If excluding those who differ in one point is not sectarianism, in heaven's name what is it? The number of those societies "whose constitution and by-laws are being amended yearly with the view of putting them upon a broader and more just and liberal basis" is exceedingly small—too small, indeed, to warrant the application of the term "non-sectarian" to their societies as a class.

As to non-sectarian investigators, we grant there are some. An investigator in the field of pathology is not likely to go far out of his way to exhibit his bias in therapeutics, although such excursions are not unknown; but let him investigate in the field of materia medica and therapeutics, and his attitude becomes evident. An examination of the results of the labors of such investigators is enough to make the gods laugh. To see the pitifully weak attempts to avoid recognizing the homœopathic principle in facts as to the action of drugs which they cannot deny; to read the inane endeavors to weaken the force of such facts by verbose explanations, and in all to meet the same unreasoning, unscientific determination to down homœopathy, not to investigate it, is to obtain a very clear conception

of the non-sectarian character of these investigations. A few more years of study and of experience with the general spirit of the dominant school will, we know, cause our neophyte to take a less optimistic view of the isolated instances of the tardy liberality occasionally met with.

We are sorry to learn that the writer is not so optimistic as to the future of homœopathy. He says, "An intelligent interpretation of the signs of the times discloses the fact that homœopathy organically has begun to decline. Here in America we are neither graduating yearly the same proportion of physicians to the number of those in practice as formerly, nor so many in proportion as do the dominant schools. And, moreover, the total number yearly graduated by homœopathic schools compares less favorably, in proportion to the growth of population, with the total of its competitors."

From the reports of the Bureau of Statistics of the American Institute of Homœopathy we learn that there were in attendance in 21 homœopathic schools, in 1900, 1391 students; in 1901, in 19 colleges, 1535. In 1900 there were graduated 295; in 1901, 347. We do not know what proportion these numbers bear to the number of those in practice, nor to the increase in population; but our writer, like so many others, leaves altogether out of view a very important fact, and that is that the profession is overcrowded. There may be an apparent scarcity in one region, but this is offset by a congestion in another. The law of supply and demand is universal in its application, overcoming eventually all artificial restraint, even when offered by trusts and unions.

The ease with which any one was able to enter the medical profession in former years caused its ranks speedily to be filled, and to establish an exaggerated proportion to the increase of population. The effects are being felt at the present time. How many ex-doctors, principally from the ranks of the dominant school, do we not find peddling books, representing life-insurance companies or drug concerns? If the proportion of homœopathic physicians to the increase of population is being reduced to a more nearly normal standard, it is a cause of congratulation, and will surely soon be in evidence in the schools of our more slowly-moving competitors. It does not point to the "extermination of homœopathy as an organic entity"—unless we follow the advice of the writer.

He says, "It is idle to expect homœopathic materia medica to be taught as such in the non-sectarian schools." The force of this remark evidently lies in the "as such." If it were taught as homœopathic materia medica, and not as a part of general materia medica, the schools would thereby confess themselves sectarians of the worst sort, who had not investigated its claims nor the facts which substantiate them. His advice is, therefore, "If homœopaths, however, so far as possible, associate themselves with medical societies which have as requirements for admission no condition conflicting with their own, they will by degrees promote an ever-increasing friendly spirit." "We must give, if we would receive. We should be prepared to relinquish certain things to which we attach importance, and expect concessions in return" (which we wouldn't get.—ED.). "If the policy outlined is wisely pursued, the integrity of homœopathy would be preserved, thus guaranteeing, when the time is ripe, continued recognition. If, on the other hand, the present course is continued, its extermination as an organic entity is certain." Give—give—give. Humbly crawl in wherever a loop-hole has been left for boneless bodies to enter. If we do this wisely, *i.e.*, diplomatically, dropping the H after our names in the directories, and saying, instead of *similia similibus curantur*, the therapeutic action of small doses is the opposite of the physiological action of large ones, we may hope for recognition "when the time is ripe." How sweet and consoling!—but how unconvincing. With such means to obtain an end we have no sympathy, even were the end most desirable. But what do we care for the recognition of homœopathy by the dominant school, except as it will benefit its members and the public? Is it of such paramount importance that it is to be bought by the surrender of a principle? Let us strengthen homœopathy by scientifically investigating and defining its scope, and by accumulating reliable proofs of the applicability of its principle. It can then stand by itself, as the science of therapeutics, demanding, not soliciting, recognition from all really non-sectarian investigators.

After all this kindly-meant criticism, we are happy to be able to agree most heartily with one suggestion of the author of the paper, as a consummation devoutly to be wished, although we place it at the end—not, as he does, "as the first step

in the evolution of the present system of medical organization." "The first step should be in the direction of placing the sectarians in a position analogous to that now enjoyed by the societies embracing the various specialties, namely, affiliative relationship to the great body of general medicine; a plan which is not only ethically, scientifically and organically sound, but, as well, the most just and feasible solution of the problem." It is, therefore, as we say, the final solution of the problem. Homœopathy is a specialty. Let it develop as a specialty, and be ready to take its place in the body of general medicine as such; and when the millenium comes, its claims will be recognized.

DR. RICHARD HUGHES.

"Richard Hughes"—as we American physicians affectionately called him—has passed across the bourne to his reward. The news of his departure comes to us as a surprise. For three decades the homœopathic profession had lived so continuously within the circle of his intellectual radiance that we had no occasion, or thought we had none, to contemplate what the doing without him would be like. His life was fruitful of nought but good, and his death impresses us most strongly with a sense of something lost to the brotherhood of homœopaths. We are reminded of the sentiment of Holmes:

"The beacon flame that fired the sky—the brilliant ray that gladdened us—
A little breath hath quenched its light, and deepening shades have saddened us.
No more our brother's life is ours for cheering or for grieving us:
One only sadness he bequeathed—the sorrow of his leaving us."

It can be truly said of this distinguished physician that his entire professional life was devoted to tireless labor in the interests of medicine and of its practitioners. He is known to all his School by his "Manual of Therapeutics" and his "Pharmacodynamics," but his name will be most perpetuated by his authorship of that gigantic work, the "Cyclopædia of Drug Pathogenesis"—a work without a parallel in all medical literature. It is a work—we had almost said *the* work—from which the future Materia Medica authority will chiefly compile

all that is best and most reliable in his new text-book; and it requires no prophetic vision to foretell that its pages will be even more frequently explored at the end of the twentieth century than at its beginning. Not only in his more pretentious volumes, but also in our periodical literature, Dr. Hughes has been for a long series of years an earnest and efficient laborer and leader. The old *British Journal of Homœopathy*, and, in more recent years, the *Journal of the British Homœopathic Society*, were the objects of his never-wearying care. For twenty years he served as the efficient and successful Secretary of the International Homœopathic Congress—a position involving unrequited toil, unflagging patience and consummate skill. It is significant of his interest in literary work that at his death, which occurred while on a visit to Ireland, he was found in possession of the proof-sheets of the April number of the Homœopathic Society's *Journal*, partially corrected for the press.

Dr. Hughes's influence was potently exerted in the direction of an intelligent adherence to Hahnemann's rule of therapeutic practice and a scientific and genuine materia medica. For a number of years he was warmly interested in the work of the Materia Medica Section of the American Institute of Homœopathy, and greatly encouraged his friend and co-laborer, Dr. J. P. Dake, who was at that time the Chairman of the Section. His disapproval of the laxity current in the practice of many homœopathic physicians was quite forcibly expressed at the session of the International Homœopathic Congress at Atlantic City in 1891. Discussing an essay by the learned Dr. Lilienthal, he said: "Eclecticism—using the term in its etymological and historical meaning—eclecticism, whether in religion, or philosophy, or in the practice of any art, is a temptation. If we could 'sit as God,' viewing all forms of creed and conduct, and choosing the best, it were indeed our wisest and ideal position. But we are not God, and the danger for men is that, if they attempt to pick and choose, to select the good wherever they can find it, the temptation is to drift into lawlessness, to lose all grounding principles and guidance of rule, and have nothing definite to look back upon when they review their practice. I do not think that any one who knows me will suspect me of illiberality or narrowness when I say that the temp-

tation to eclecticism in therapeutics is a temptation that ought to be resisted."

It would thus appear that our departed colleague held the view that a physician claiming to be intelligent should first examine the groundwork of his belief in homœopathy, and, having adopted that method of practice, he should either submit his practice to the guiding influence of the law of cure or else re-examine his foundations with a view to changing his belief. He had no patience with that grotesque "science" (?) which loses its bearings before every "wind of doctrine" and submits to the direction of speculation or of impulse rather than the guidance of his chart and compass, however old-fashioned these may be.

To our mind, the life and work of Richard Hughes have imparted to medicine a distinctly forward impulse. Had he never lived, the world of medicine would not be just where it now is. Neither would it be endowed with its present forward momentum. Particularly is this true of the present disposition to remain unsatisfied, or dissatisfied, with a *materia medica* which fails to meet the requirements of Hahnemann's ideal, and which excludes everything that is mere assertion or conjecture. This endowment of progressive energy will one day lead on to some conservative and wise method by which the elements of our pathogenesis will either prove their right to a place in the accepted *materia medica* or stand aside and wait for the approval of scientific modes of investigation. Towards this point the medical sentiment of the age is trending, and that largely through the teaching and the life-work of Richard Hughes.

PEMBERTON DUDLEY.

HINTS ON NUX MOSCHATA.—Dr. J. C. White relates an interesting case of menstrual headache, which had occurred, periodically, for over twenty years. The pain in the head would commence the week previous to the flow. The patient obtained her only relief from clasping her hands tightly over her head. Ignatia, prescribed upon this modality, failed. *Nux moschata* afforded quick relief. This modality, relief from hard pressure, seems to be one reliable indication for the remedy, because several writers have recently referred to it. Dr. Boger remarks that the *nux moschata* is one of the remedies that, like *cannabis indica*, has a false perception of distance. The patient therefore imagines that objects are at a greater distance than is really the case. Bonninghausen recommended it as a very reliable remedy for impotence.—*Med. Advance.*

WILLIAM TOD HELMUTH, M.D., LL.D.

HAHNEMANN, 1853,

HOMŒOPATH,

SURGEON,

SCHOLAR,

TEACHER,

AUTHOR,

POET.

FIRST A. R. Thomas, of Philadelphia, next Talbot, of Boston, then Ludlam, of Chicago, then Richard Hughes, of England, and now Helmuth, of New York—one after another the different medical centres have lost their strong and wise leaders. Death came to our Helmuth more kindly than to Thomas, or even to Talbot, for he, like Ludlam, was suddenly taken while in the harness. He had written his poem for the Talcott dinner, and even as it was being read by another, on account of his absence from a supposedly slight indisposition, he breathed his last.

Helmuth needs no eulogy either to the profession in which he was so active nor among those who knew him; but there are those, perhaps, who do not fully appreciate his services while admiring his attainments. In a school whose distinctive feature is a therapeutic law and its evolution, his work was not the development of materia medica, the proving of drugs, or the application of their symptoms to the sick. And yet he served his school as well as Hering and Farrington, or Raue and Allen. Graduating at a time when the ostracism of an intolerant profession left this small band of therapists without surgeons, obstetricians, oculists, aurists, etc., to support them, he fathered the specialists who have enabled us to become independent of the majority and reach the position and numbers of the present.

From the day the student in his teens jumped over the rail and held the clinic for his fellows in the absence of the professor, Helmuth has been the surgical leader, with his ready hand, his diagnostic acumen, his scholarly writings, his eloquent teaching; and then, to divert the wearied mind of the over-worked doctor, he added his keen wit and poetic pen.

One who has known him, has admired him, has respected him,

as has the writer, can truthfully say, as the curtain is drawn over this brilliant career, "Well done, good and faithful servant."

May the example of his life serve to stimulate others, so that we may have, if not as brilliant, yet many more surgeons of this skillful, thorough, scholarly and educational type.

WILLIAM B. VAN LENNEP.

THE CLEVELAND MEETING.

WITH that commendable promptness which characterizes his every action, Dr. Charles Gatchell, Secretary of the American Institute of Homœopathy, has issued the annual circular announcing the arrangements and programme of the Fifty-Eighth Annual Meeting of our National body to be held at Cleveland, Ohio, June 17 to 21. The arrangements made by the Cleveland physicians for our entertainment and comfort are such as to assure us a most profitable and enjoyable occasion. As we have stated in a previous number of this journal, we believe that this meeting will prove advantageous to the Institute as an organization. Cleveland is so accessible by railroad that the attendance should be unusually large. Moreover, it has been so many years since the Institute has met in the country tributary to Cleveland, that the Institute should have an unusually large influx of new members.

While not pertaining strictly to the Cleveland Meeting, we cannot refrain from referring to a matter of the greatest importance to the success of organizations issuing annual volumes of *Transactions*. In the past, certain remarkable derelictions of duty on the part of the officials having such publications in charge have been called to our notice. The 1901 proceedings of the Institute did not appear until May 1, 1902, or over ten months after the adjournment of the meeting. Another society meeting in September, 1901, still remains to be heard from, notwithstanding the standing resolutions of said society require their publication by January 1, 1902. We know the difficulties under which secretaries labor, and can excuse some delay; but procrastinations such as we have instanced imperil the safety of our organizations. They are inexcusable. Taking the Institute for example, it was formerly the rule, and we be-

lieve such rule still exists in theory, that the reports of the official stenographers shall be in the hands of the secretary within two weeks after adjournment. Said reports of discussions are then to be sent to the different debaters for revision, and must be returned corrected within another two weeks. In default of this, the secretary is empowered to go ahead with their publication despite the action of the derelicts. This we regard as a good rule. In the past it has been honored more in the breach than in the observance. Discussions have been received by the debaters in the middle of August, when most of them are away on their vacations. The result is that discussions are not corrected and returned to the secretary until the middle of September. The work is next put in the hands of the printer, and should be pushed ahead at the rate of at least 16 pages daily. Unfortunately, all is not smooth sailing even then, for it has been stated that authors have requested the privilege of retaining their manuscripts for further revision, and when this is granted by the secretary, it is a problem to prophesy when they will be returned. This, of course, is in direct violation of the rules of the societies in question.

Beginning with the 1902 volume, our *Transactions* will be in charge of the new secretary. We believe that he should not be hampered in his work by vexatious delays, and that he should be upheld by every essayist and debater in his efforts to bring the volume out on time. If, in the performance of his duties, he should insist upon a strict enforcement of the rules, he should be commended, and not criticized. We are impelled to make these remarks because the secretary of the organization, still in default in its *Transactions*, assures us that he permitted some authors to retain manuscript for correction, and at this late date he has not been able to secure its return. It is *possible*, with promptness, to give the Institute *Transactions* out by November 1st. Allow four weeks for transcribing and correcting the debates, during which time the secretary is engaged in arranging his material, the entire volume should be in the hands of the printer by the middle of July. Printing 1000 pages, at the rate of 16 pages daily, should complete the volume by September 30th. Allow one month for indexing and binding, and that brings us to October 31st. Of course this schedule is useless if members will presume upon good nature to delay the secretary in following it out.

GLEANINGS.

THE DANGER OF TOO LARGE DOSES OF MERCURY, OR THE "INTENSE" TREATMENT, IN SPASMODIC SYPHILITIC PARAPLEGIA.—Dr. Marie, of Paris, called attention in the Parisian Hospital Society to the dangers of "pushing" mercury in spasmodic syphilitic paraplegia. The drug may be tried when the paralysis appears only as a slight defect in walking, or in a patient who is suddenly seized with paralysis of all four members, or with a paraplegia combined with hemiplegia. In the advanced stages of the disease, after it has lasted from eighteen months to two years, one should be very cautious in administering mercury, for it will tend to aggravate rather than to ameliorate the motor disturbances. At the most it is allowable to prescribe the less active preparations, as the protoiodide, Gibert's syrup, the oily preparations of the biniodide, etc. This rule also applies to the tabetospasmodic type of syphilitic myelitis. On the contrary, in tabes and general paralysis the "intense treatment" in cases of syphilitic origin, at least in the beginning of the disease and at any time before it becomes well established, may yield favorable results.

Frank H. Pritchard, M.D.

PRIMARY TUBERCULOSIS OF THE LIVER.—(Frank.)—If we remember that the tubercle bacillus may gain entrance into the body, and leave no trace of its mode or place of entrance; that they find their way into the alimentary tract and produce lesions without lesions higher up; that the blood from the intestinal tract canal passes through the liver by means of the portal circulation, it seems probable that we ought to find hepatic tuberculosis oftener than we do. However, after reviewing the literature, he comes to the following conclusions:

- (a) Primary tuberculosis of the liver may occur, although it is rare.
- (b) That the infection may take place by the way of the intestine and the portal circulation, the bacilli finding their way through an ulcer in the bowel, and leaving no trace of entrance.
- (c) Tuberculosis of the liver may affect other viscera and the peritoneum secondarily.
- (d) Resulting we may have an interstitial hepatitis.
- (e) The disease is usually fatal within twelve months.

DIAGNOSIS AND TREATMENT OF CANCER OF THE RECTUM.—(Ross.)—The earliest symptom is a discharge of blood and mucus or bloody mucus. Later, when the lumen of the gut is narrowed, we have the characteristic ribbon-shaped stool. Another symptom which should attract attention is the alternating diarrhoea and constipation. Again, the age of the patient will be of service in our diagnosis. Pain in growths about the anus is an early symptom, while in those situated higher up it comes on late. It often arises from the passage of the faeces over an ulcerated surface or from pressure of the

growth. When pain involves the lower extremity, it is due to encroachment of the neighboring nerves. We have also a loss in weight and strength and cachexia. The defecation becomes more difficult and more painful. Lymph glands in the groin and pelvis may show early involvement.

There are five varieties of cancer—epithelioma, scirrhus, encephaloid, colloid and melanotic.

Treatment.—Colostomy offers the best palliative measure. As Kelsey puts it, "Colostomy, especially inguinal colostomy, relieves pain, does away with the constant tenesmus and discharge from the rectum, which by their exhausting effects are the cause of death; delays the development of the disease by preventing straining and congestion from defecation; prevents bowel obstruction; enables the patient to gain flesh." Another use of colostomy is as a preliminary step to further interference. The only hope of cure, be it ever so faint, is early and complete extirpation. Of course, an early diagnosis is essential to this procedure; therefore the thorough examination of all rectal cases is advised.—*Medicine*, March, 1902.

William F. Baker, A.M., M.D.

PRESENT METHODS OF TREATING URETERS SEVERED DURING ABDOMINAL OPERATIONS.—Nicholson (Philadelphia), in an exhaustive paper, reviews the present status of urethral surgery. The procedure of nephrectomy for a severed ureter, first done by Simon in 1871, is unreservedly condemned. The method of aseptic ligature of the severed ureter should be reserved for those few cases in which the time element is of paramount importance. The different methods of uretero-ureteral anastomosis are given as follows: 1. Lateral implantations, or the end-in-side method, originated by Van Hook. 2. Transverse end-to-end approximation. 3. Oblique end-to-end approximation, or Bovee's method. 4. End-to-end, done by various experimenters, and once successfully in a human case.

In all cases of injury occurring below the pelvic brim the operation of uretero-cystotomy is to be thought of. Sanger's forceps or Kelly's ureteral guide can be here used to advantage. The objections to the operation are, infection of the kidney, or hydronephrosis, from constriction of the ureter, or too free opening and backward flow of urine. Uretero-cystotomy is a much easier operation than uretero-ureteral anastomosis, and on this account is recommended, whenever practicable, by Baldy.

Intestinal anastomosis, although practiced to a certain extent, is open to the insurmountable possibility of ascending infection, which involves the majority of all ureters thus anastomosed. The author claims that the operation of uretero-trigono-intestinal anastomosis, while admittedly very serious, is justifiable in cases in which the only alternative is removal of the kidney, or in which malignant disease demands the removal of a large portion of the bladder. Rectal implantation, tried experimentally by Kalabin, is open to the same objection of ascending infection. Barbat suggests making use of a loop of intestine, one end of which is inserted into the bladder, and to the other end the ureter is attached. This method adds to the already formidable double anastomatic operation the dangers incident to a resection of the gut.

It is interesting to note here that Peterson has shown that the kidney may develop an immunity to infection from the colon bacillus, but the cost of the development of such immunity is extensive changes of a cirrhotic nature.

The vagina as a site for ureteral implantation has the advantage of reservoir

space, and Boyce considers it preferable to the simple bowel implantation. Boari reports a case of anastomosis between the ureter and the urethra. The man recovered. Lastly, skin implantation of the severed ureter is mentioned only to be condemned, and Kelly considers the operation in the same class with nephrectomy.—*The American Journal of the Medical Sciences*, April, 1902.

Gustave A. Van Lennep, M.D.

BONE CYSTS.—Corson (Savannah, Ga.) reports the following interesting case: A young woman when fifteen had an attack of typhoid fever. Two years later there was pain in the right arm, which was thought to be rheumatic. A year after that she suffered a fracture of the right humerus while being helped from a train, at a point where she had previously suffered the most pain. The fracture was diagnosed and set under an anæsthetic, and the bone eventually united. The pain, however, persisted and became worse, so that she finally entered a hospital.

A skiagraph showed the lower half of the humerus involved in a spindle-shaped swelling, the upper part of which cast a much lighter shadow. A provisional diagnosis of osteo-myelitis was made. On operating by a posterolateral incision, the periosteum was found thickened and intimately adherent to the underlying bone, which was so thinned that it could be easily cut with a pair of scissors. On opening the latter about an ounce and a half of a clear brownish fluid of the consistency of synovia escaped. The cavity in the bone was an elliptical space about eight centimeters long and three centimeters wide, and lined by a membrane having the feel of a mucous membrane. It was not curetted, but packed with iodoform gauze previously wrung out of corrosive sublimate solution. The patient made a good recovery, although two years later there was still a small sinus, with a slight discharge.—*Annals of Surgery*, April, 1902.

Gustave A. Van Lennep, M.D.

THE POSSIBILITY OF TREATING MITRAL STENOSIS BY SURGICAL METHODS.—Sir Lauder Brunton, discouraged by the resistance to medical treatment offered by the severe forms of mitral stenosis, communicates to *The Lancet* (February 8, 1902) his wish that one could divide the constriction as easily during life as one can after death. The risk which such an operation would entail naturally makes one shrink from it, but, in some cases, it might be well worth while for the patients to balance the risk of a shortened life against a prolonged existence worse than death. His limited time has not allowed him to more than make trial experiments of dividing stenosed valves in diseased hearts from the post-mortem theatre and on healthy valves in the hearts of cats, but he offers this suggestion in order that surgeons may carry out the necessary preliminary experiments. The good results that have been obtained by surgical treatment of wounds in the heart embolden one to hope that before long similar good results may be obtained in cases of mitral stenosis.

F. Mortimer Lawrence, M.D.

A NEW OPERATION FOR RETRODISPLACEMENT.—(Baldy.)—This operation has been described by Webster, of Chicago. It consists in perforating each broad ligament from its posterior aspect, and dragging the round ligament through the opening and fastening it behind the uterus. In some cases the tension on the loop of round ligament is such that the stitches will cut out, and in such cases the round ligament can be severed from its anterior uterine attach-

ment, and the stump sutured to the posterior surface of the fundus uteri. The advantages of this operation are that it tilts the uterus forward beyond the line of axis of the pelvis, and holds it in such position that when intra-abdominal pressure is made the womb tends to move toward the bladder, and not toward the hollow of the sacrum. It forms a perfect sling behind the uterus, which may be or may not be attached to the uterus, as the operator chooses. The uterus remains in the pelvis as a pelvic organ. The disadvantages of this operation are that in carrying this procedure out the round ligaments are doubled on themselves; and when attached together behind the uterus there is often so much tension as to make it probable that some of the sutures will cut out.

The effect of pregnancy after this operation remains to be determined.—*American Journal of Obstetrics*, May, 1902.

George R. Southwick, M.D.

HAS THE FATHER OR THE MOTHER THE GREATER INFLUENCE ON THE VITALITY OF THE CHILD.—(Hoppe.)—Ruppin draws the conclusion from the statistics of Christians, Jews and mixed parentage, that the man has a preponderating influence on the vitality of the child. Hoppe believes that a biological law accounts for it, and gives a simple explanation. He states that the Jews have a considerably greater vitality and a correspondingly lower vitality than the Christians, as they suffer less from dangerous and critical infectious diseases, and also suffer less from organic diseases, as of the heart and kidneys. Tuberculosis, syphilis and alcoholism are much more rare among them, all of which occur in the periods of the greatest vitality of the organism. The evil effects of syphilis and alcoholism on fecundity are well known. There is greater infant mortality among the Christians than among the Jews.—*Centralblatt für Gynäkologie*, No. 7, 1902.

George R. Southwick, M.D.

DIABETES IN WOMEN, AND ITS RELATION TO PREGNANCY.—(Lesse.)—Heredity is of some importance as a cause of diabetes, and it is often limited to one line or side of the family; but the disease does not appear to be conveyed from one person to another, even when living in the most intimate relations. Cases where both husband and wife are affected are due rather to both parties being subject to the same diet and living under like conditions, and having similar cares of life. Diabetes is more rare in women than in men. It is least frequent before puberty, increases during the childbearing period, and diminishes again in old age. Obesity from high living and a sedentary life predispose to diabetes, which has been termed constitutional diabetes, and is more common in women, in contrast to neurogenous or accidental diabetes occurring after injuries or alterations of the nerves, which occurs more often in men.

The earlier diabetes occurs, the worse is the prognosis. A young girl suffering from this disease should not marry. The childbearing period of life brings with it many complications of a serious character. If in young women there is a gradual diminution of the menstrual flow, and amenorrhœa occurs, the urine should be examined for sugar. Pruritus vulvæ is a common symptom, and is due to a fungus in the hair an account of the fermentation of the particles of sugar deposited in it. The uterus is apt to be small and atrophic, and the ovaries as well. Hofmeier calls this secondary atrophy, in consequence

of the general disturbances of nutrition caused by the diabetes. Numerous cases of general atrophy of the genitalia, with premature menopause, have been observed. Pruritus may not occur for three or four years, though it may be one of the first symptoms. The itching and burning causes some pain, especially at night, and spreads gradually to the perinæum, inguinal regions and abdomen. The turgescence of the vulva and the constant hyperæmia and scratching lead to hyperplasia of the tissues, a true pachydermia of the skin. The constant itching, burning, pain, loss of sleep, constipation and diminution of the appetite soon lead to a diminution of nutrition, and shorten life. Fig warts have been observed as a consequence of the local irritation.

Diabetes in pregnancy may be due to absorption of milk-sugar from the mammary glands, especially when the secretion of milk is profuse, and it appears more frequently when the mammary glands are highly developed. It has been observed when the glands have been overdistended with milk for some time. Ney made a study of this subject in 148 lying-in women, and 4 cases had sugar in the first 115. He notes that where there was no secretion of milk there was no sugar either before or after labor. There was no sugar with a moderate secretion of milk. If the secretion was excessive, there was always sugar in the urine. The sugar in the urine in these cases was milk-sugar, a fact which has been confirmed by several observers.

These cases of sugar in the urine of pregnant and nursing women must be separated carefully from those of true diabetes. In general, it may be said that very few diabetic women become pregnant. Sexual activity usually ceases in these cases.

Pregnancy, complicated by diabetes, is very dangerous to both the mother and her child. The sugar diminishes very soon after labor, but it soon increases again more than before. The children are poorly developed, and are liable to have hydrocephalus. In nearly half of the cases labor comes on prematurely at about the seventh month, and about half of the women die later from coma or tuberculosis. Forty per cent. of the children die. Nursing the child should be forbidden, as it aggravates the disease.

Premature labor should not be induced in diabetic women except for a contracted pelvis or hydramnion, as any operation involving the use of instruments or an anæsthetic is dangerous, and lesions of tissue, which are liable to occur, do not heal readily.

Diseases of the mucous membrane of the uterus are the only uterine diseases directly associated with diabetes, as shown by the numerous observations of menstrual disturbances with diabetes, which frequently begin with profuse menstruation. Diabetes and carcinoma of the uterus very rarely co-exist.

It is the generally accepted opinion that no operation should be performed on a diabetic person, except in very urgent cases, until the sugar in the urine has been reduced to the minimum by anti-diabetic treatment and diet. Diabetic persons who have no symptoms other than sugar in the urine may develop fatal coma after an anæsthetic which seems to interfere with the metabolism in the body. The wounds of a diabetic show a marked tendency to gangrene. The following is a brief summary:

1. A woman suffering from diabetes is liable to serious danger if she marries.

2. The urine of each parturient woman should be examined for sugar when possible.

3. The prognosis of diabetes before the beginning of pregnancy is better than when it develops during pregnancy.

4. Most of the cases of diabetes developing primarily during pregnancy commence in the last half.

5. The induction of premature labor is only advisable in hydramnion and contracted pelvis.

6. The urine should be examined for sugar before any operation.

7. Operations on diabetic patients should not be performed unless delay in operating means a greater danger to the patient than the diabetes.—*Monatschrift für Geburtshilfe und Gynäkologie*, April, 1902, H. 4.

George R. Southwick, M.D.

THE INDICATIONS FOR THE SURGICAL TREATMENT OF CHOLELITHIASIS.—Berg (New York) asserts that medical treatment can only bring about either expulsion of the calculi from the biliary system or subsidence of the disease into a latent state. He offers the following conclusions as to the indications for medical and surgical treatment respectively :

a. Indications for Medical Treatment.—Cholecystitic pain or attacks of biliary colic, in either case unattended with fever.

b. Indications for Surgical Treatment.—(1) Operations of choice—undertaken in the quiescent period with the object of avoiding serious complications ; a simple procedure, and followed by 2 to 3 per cent. mortality. (*a*) Severe cholecystitic pain, or oft-repeated uncomplicated attacks of biliary colic, persisting in spite of medical treatment, in virtue of which the patient becomes invalided and incapacitated for work ; (*b*) after the first attack of cholecystitis, associated with fever.

(2) Compulsory operations—undertaken at any time of the day or night, often amidst unfavorable surroundings, and in patients who are septic, emaciated, and of low vitality. Difficult and laborious procedures, and attended with high mortality—50 to 75 per cent. (*a*) Foudroyant and intensely acute attacks of cholecystitis. (This may be the first indication of calculous disease, but usually follows previous milder attacks.) (*b*) Hydrops, empyema, gangrene, or perforation of the gall-bladder, cholæmia, abscess of the liver, and diffuse peritonitis.—*Med. Rec.*, May 3, 1902.

F. Mortimer Lawrence, M.D.

HYOSCINE IN THE TREATMENT OF PARALYSIS AGITANS.—Judson S. Bury (London) records, with considerable detail, two cases of paralysis agitans, occurring in a brother and sister. The onset was unusually early in life, *i.e.*, at the age of 35 years in the man and at 18 in the woman. Both patients were treated by massage and by the administration of hyoscine. At first this drug was given hypodermatically, the dose being gradually increased from $\frac{1}{320}$ th to $\frac{1}{120}$ th of a grain daily. As the larger dose produced nausea, dryness of the mouth, and giddiness, the injections were discontinued, and the hyoscine given in chloroform water by the mouth. At first $\frac{1}{150}$ th of a grain was given twice daily, and the dose was gradually increased to $\frac{1}{90}$ th of a grain. This amount produced no ill-effects and greatly mitigated the symptoms.

Judging from his experience, Bury agrees with Williamson that hyoscine is probably the most useful drug that has hitherto been tried in the treatment

of paralysis agitans. It is safer when given by the mouth. Merck's lysocine hydrobromate is probably the best preparation.—*The Lancet*, April 19, 1902.

F. Mortimer Lawrence, M.D.

HYDRASTIS CANADENSIS IN GOITRE.—Cuthbertson, in a paper read before the Chicago Medical Society, defines goitre as a non-inflammatory enlargement of the thyroid body, either general or partial, and divides it clinically into (1) vascular; (2) hypertrophic or parenchymatous: (a) simple, (b) miasmatic, (c) exophthalmic; (3) adenomatous cystic; (4) pneumatic; (5) malignant. The goitre of puberty and pregnancy belongs to the vascular and simple hypertrophic types. In one such case hydrastis canadensis proved efficacious, and this led to its use in a series of 25 similar cases which came under his care. In each of these a cure was effected in from six weeks to three months by the administration of hydrastis canadensis, three times daily, after eating. He was well aware that some of these cases might have got well without treatment, but he made no selection of them, taking them as they presented themselves. One of these cases which was cured by this means had been treated with iodine and the iodides, and with thyroid extract, becoming much worse under both forms of treatment. He presented hydrastis canadensis as a new and successful remedy in the goitre of puberty and pregnancy.—*Med. News*, April 5, 1902.

F. Mortimer Lawrence, M.D.

THE PATHOLOGY AND TREATMENT OF MALIGNANT ENDOCARDITIS.—At a meeting of the Royal Medical and Chirurgical Society, held on April 22, 1902, Dr. William Ewart and Mr. A. S. Morley contributed a paper on "The Possibility of Recovery from the Active Stage of Malignant Endocarditis." Three fatal cases, with the post-mortem findings, were reported in detail. The writers thought that inunction of protargol (20 per cent. ointment) had proved beneficial, and the improvement noted encouraged the hope that more powerful remedies might be found, and that malignant endocarditis might cease to be regarded as practically incurable. Dr. Ewart added a note to the effect that in his belief intravenous injection of antiseptic agents seemed to be indicated in this disease.

In the ensuing discussion, which also had to do with a report of Poynton and Paine confirmatory of their discovery of the diplococcus rheumaticus, Dr. A. E. Sansom affirmed that many cases recovered partially or for a time. He had not been favorably impressed with treatment by antistreptococcal serum. Dr. D. B. Lees congratulated the investigators on having proven, first, that rheumatic fever was due to a specific diplococcus, and, secondly, that this same microbe was capable of producing in some rabbits simple rheumatic fever, and in others what was to all intents and purposes malignant endocarditis. Malignant endocarditis might undoubtedly be produced by many infections, and this proved that the rheumatic diplococcus was one of them. He regarded it as probable that rheumatoid arthritis was capable of originating from several causes, one of which was very likely to be diplococcus rheumaticus. Dr. E. W. A. Walker reported that he had (with Dr. R. M. Beaton) investigated four cases, and in all he had found the diplococcus rheumaticus. The first was a case of infective endocarditis; and in this he also found staphylococcus, but it was of a non-infective kind. The same two microbes had also been found in a case of chorea, and also in another case of bilateral pleural

effusion. Experiments had also been made on animals, and the disease reproduced in them. All the investigations which he and Dr. Beaton had made had amply confirmed the researches of Dr. Poynton and Dr. Paine.—*The Lancet*, April 28, 1902.

F. Mortimer Lawrence, M.D.

TREATMENT OF DYSENTERY.—(Hare.)—Generally speaking, the disease may be modified to a considerable extent by early treatment. All foods should be of such a character as not to leave a great amount of residue which would act either as an irritant to the large bowel or produce conditions which would favor the further development of the bacillus. Milk does not seem to be the best article of diet in these cases. If it is given it should be peptonized, or mixed with lime-water, barley-water or vichy. As equally important is, that definite quantities be given at regular intervals, and that these quantities should not be large. Semisolid food, as milk-toast, soft-boiled egg, etc., will often be found to be of greater service than the liquid food.

Local Treatment.—Copious injections of the sulphocarbolate of zinc (20 gr. to the pint), weak solutions of nitrate of silver. When the weather is intensely hot and the patient febrile, the free use of iced water will be of great benefit. There is one precaution in the use of ice water, and that is, that it should not be used unless it is grateful to the patient. The tenesmus and the irritability can at times be greatly relieved by the use of a 10-gr. iodoform suppository some little time before the injection.

The method of giving the rectal lavage is of importance. A fountain-syringe or rectal irrigator should be used. The injection should be gently given. When there is great irritability, it is better to use a two-way irrigator or two soft-rubber catheters side by side, since in this way great distention of the bowel can be avoided. The use of warm or tepid water is to be avoided, as it is relaxing, and does not possess the stimulating properties of extreme heat or cold.—*Therapeutic Gazette*, April 15, 1902.

William F. Baker, A.M., M.D.

FURTHER STUDIES OF GRANULAR DEGENERATION OF ERYTHROCYTES.—(Stengel, White and Pepper.)—In a previous paper the relation between lead poisoning and the degeneration in the red cell was pointed out. From further investigations, the writers are prepared to express a positive belief that the granular degeneration is the result of protoplasmic changes rather than the consequence of nuclear division. The evidence from their investigations may be summarized as follows:

1. Karyolytic and karyorrhexic changes may be observed in the nucleated red cells without showing granular degeneration in the protoplasm of the cell, and granular degeneration may accompany these nuclear changes without association of the nuclear and granular processes.

2. The granulated red cells never show the remains of a former nucleus.

3. The granules are observed in karyokinetic red cells, and we have seen them associated with the several stages of the dividing nucleus. We cannot believe that such a progressive and retrogressive change can be present in the nucleus at the same time, without internal evidence of degeneration.

4. The very early appearance of these granules in the blood taken from the peripheral circulation (twenty-four hours after a dose of $7\frac{1}{2}$ grs. of acetate of lead has been taken by one of us), to a certain extent indicates a probable

beginning of the destructive changes in the erythrocyte (non-nucleated) of the peripheral blood, rather than in the erythrocyte (nucleated) at the moment in process of formation in blood-making organs.

5. The granules observed in the bone marrow were absolutely the same as seen in the peripheral blood. Those in the nucleated cells, chiefly normoblasts, showed no evidence of derivation from the nucleus, the nuclei being in each case normal in size, shape, and staining qualities, and like those of the neighboring nucleated cells which did not contain granules.

6. Finally, it seems to us, in certain cases of leukæmia in which great numbers of nucleated red cells are always present, if these granules were nuclear derivations, distinct steps or transitions could be demonstrated. Such is not the case. On the contrary, distinct degenerative changes—karyorrhexis, karyolysis, pyknosis, atrophy of the nucleus, etc.—are present, sometimes with and sometimes without granular protoplasm; but there are never, in our experience, any transitional changes to indicate gradual destruction of nuclei with liberation of the substance that has gone to form granules. In addition, very many of the nucleated cells showing nuclear degeneration contain no granules.—*The American Journal of the Medical Sciences*, May, 1902.

William F. Baker, A.M., M.D.

THE UNILATERAL OCCURRENCE OF KERNIG'S SIGN AS A SYMPTOM OF FOCAL BRAIN DISEASE.—(Sailer.)—This sign was described by Kernig in 1883. His attention was first directed to the phenomenon in a patient recovering from epidemic cerebro-spinal meningitis. This patient could walk perfectly well, could lie in bed with legs extended, but whenever she sat in a chair she found it impossible to extend legs on the thigh further than the right angle. A subsequent study in cases of meningitis found this sign present in all. He describes it as a flexion contracture in the legs (and occasionally in the arms) when the thigh is flexed to the right angle on the trunk. Under these circumstances any attempt to extend the leg on the thigh meets with severe resistance, as the result of contraction in the hamstring muscles, and it is impossible to extend the leg beyond an angle of 135° , or even, in extreme cases, beyond the right angle. When the thigh is extended, the hamstring muscles are relaxed and soft. The contraction is not ordinarily associated with pain. A report of two cases, in which the sign was unilateral and appeared as a symptom of encephalitis, follows.

The conclusions are: (a) Kernig's sign may occur as a symptom of focal encephalitis, and in this condition may be present upon only the opposite side of the body. Sometimes it is associated with a spastic paresis of the leg upon that side. (b) In these cases there may be a persistent tonic spasm of the flexor muscles of the arm, which, however, does not resemble Kernig's sign in its mechanism. (c) The most reasonable explanation of Kernig's sign that we have at present is to ascribe it to an irritative lesion of the pyramidal tract that diminishes, but does not destroy, its functional activity.—*The American Journal of the Medical Sciences*, May, 1902.

William F. Baker, A.M., M.D.

SURGERY OF SPINA BIFIDA.—Knott (Sioux City, Iowa) reports four cases of spina bifida, all successfully treated by operation. In one case paralytic symptoms were present and relieved. In another case marked anæsthesia of

both lower limbs disappeared in one month. As to the variety present, two were types of meningo-myelocele, and two of meningocele.

The author draws the following conclusions:

1. Owing to the distressing nature of the affection, the high mortality should not prevent attempts at surgical relief.

2. Meningoceles, meningo-myeloceles and syringo-myeloceles may be considerably benefited by operation.

3. The improvement in function cannot with certainty be estimated before operation, and pronounced evidences of nervous disturbance are not a contra-indication to excision.

4. Asepsis is absolutely essential, and, though difficult to secure, may be maintained by exercising extreme care.

5. The plan of having the suture lines of the meninges and the overlying tissues on different planes will, in the majority of instances, prevent leakage of cerebro-spinal fluid.

6. The suggestion of Pearson to prevent the escape of this fluid during a prolonged operation by stuffing the canal with gauze, is valuable.

7. Large bony defects may be effectually closed by muscle much easier than by osteoplastic methods.

8. It is not necessary to keep the child off its back during the healing of the wound, as frequently advised.

9. Children with hydrocephalus accompanying spina bifida should not be subjected to operation.—*Annals of Surgery*, May, 1902.

Gustave A. Van Lennep, M.D.

RUPTURE OF THE AXILLARY VEIN IN REDUCING A DISLOCATION.—Shepherd (Montreal) reports the following case, which shows how easy it is to produce rupture of the axillary vein in efforts at reduction of dislocations: The patient, a man sixty-two years of age, was suffering from a subglenoid dislocation of the humerus of about five weeks' standing. Reduction of the luxation under ether was undertaken, and while the assistant was making a few preliminary manipulations, the axilla became suddenly swollen, dusky in color, the arm cold and swollen, and no pulse at the wrist. It was surmised that a large blood-vessel had been ruptured. The author at once cut down upon the subclavian, passed a temporary catgut ligature around it over a piece of rubber tubing, and then cut into the axilla. After turning out a large blood clot, it was found that the axillary vein had been ruptured near the point where the basilic is joined by the venæ comites; the vein was attached to the capsule. It was ligated above and below the point of rupture. It was then found impossible to reduce the dislocation because the tuberosities had been torn away and were firmly implanted into the glenoid fossa. They were removed, and also the head of the humerus was excised, after which the bone came easily into position. The ligature was then removed from the subclavian, and the wounds closed. The circulation in the arm returned immediately, and the patient made a good recovery, having a useful arm.—*Annals of Surgery*, May, 1902.

Gustave A. Van Lennep, M.D.

THE TREATMENT OF DISLOCATION OF THE CLAVICLE.—Moore (Minneapolis) reports a case of dislocation of the outer end of the clavicle treated by open incision and wiring after the usual mechanical treatment had failed. On cutting down to the bone it was found that the acromio-clavicular ligaments had been pushed down underneath the end of the bone, and acted as

an impediment to the reduction of the dislocation. The author claims that, on account of this, reduction after a complete dislocation and retention is impossible, save through an open wound. Partial dislocations may be successfully treated by the usual non-operative measures.

On account of the superficial position of the bones, and the fact that this joint is a moving point, silver wire should not be used, or, if used, it must be removed after firm healing has taken place. In the case reported the sutures were showing through the skin at the end of five weeks, and were removed. The result was perfect. It is recommended that chronicized kangaroo tendon be the suture material, on account of its strength, elasticity and long life.—*Annals of Surgery*, May, 1902.

Gustave A. Van Lennep, M.D.

LEUCOCYTOSIS AS AN AID TO THE DIAGNOSIS OF PURULENT DISEASES OF THE GENITALIA.—(Dützmann.)—The writer conducted a series of examinations in such cases as suppurating and non-suppurating pelvic cellulitis, pelvic abscess, gonorrhœal salpingitis, suppurative hæmatocele, carcinoma corporis uteri, pyometra, sactopyosalpinx, etc. These studies showed the invariable increase of the white blood-corpuscles in purulent disease of the pelvic organs. The writer urges the great importance of the count of the white blood-corpuscles as a reliable aid in making a differential diagnosis.—*Centralblatt für Gynakologie*, No. 14, 1902.

George R. Southwick, M.D.

THE TREATMENT OF INVERSION OF THE UTERUS BY BISECTION OF THE CERVIX.—(Küstner.)—The writer opens the cul-de-sac of Douglas freely, inserts the finger from behind as a guide, divides the stricture about the inversion, and splits the posterior wall of the uterus as nearly as possible in the median line. This bisects the cervical portion of the uterus and divides the peritoneal covering. The forefinger is then hooked over the constricted part, and the thumb placed on the fundus of the uterus. The cut margins of the uterus are held apart with volsellum forceps, and the uterus reinverted through the opening. The wound is then united with catgut and the cul-de-sac of Douglas closed. Splitting of the anterior wall requires separation of the bladder from the uterus, the cut surfaces cannot be reunited so exactly, and it is not so rational an operation.

In a case of inversion of the uterus by a tumor, the growth was removed by the thermo-cautery, and three weeks later the uterus was reinverted by the above operation. Westermarck and Borelius have modified this operation by splitting the posterior uterine wall out into the vaginal insertion. The uterus is then drawn forward, the cut surfaces adjusted, and the sutures inserted. The uterus is then reinverted and the sutures tied.—*Beitrag zur Geburtshulfe u. Gynakologie*, Bd. v., H. 3.

George R. Southwick, M.D.

PAPILLARY TUBERCULOSIS OF THE CERVIX UTERI AND COMMUNICATION OF THE TUBERCULOSIS BY COHABITATION.—(Glockner.)—The patient was a childless woman, æt. 29, who had a tumor about the size of a walnut on the cervix. Both lips were about equally involved with a soft, spongy, villous, easily-bleeding growth, which also extended to the right side of the vagina. No alteration of the organs. The papillary masses were removed and the surfaces cauterized with thermo-cautery. The uterus was then extirpated by the vagina, which was followed by recovery. Microscopic examination showed the pathological changes and bacilli characteristic of tuberculosis in the cer-

vical and corporeal endometrium and uterine ends of the tubes, but the serous covering of the uterus was entirely free from tuberculosis.

The husband had an enlarged right testicle and epididymis, and on its lower surface there were prominent, hard nodules, the size of peas. The writer diagnosed this as tuberculosis, caused by infection from coitus. Tuberculosis may produce tumors which can scarcely be distinguished from malignant growths, except by very careful histological examination.—*Centralblatt für Gynakologie*, No. 14, 1902.

George R. Southwick, M.D.

VAGINAL INCISION AND DRAINAGE IN ACUTE PELVIC PERITONITIS, SALPINGITIS, AND CELLULITIS.—(Polk, B. McE. Emmet, Janvrin, Grandin, Boldt, Coe.) Polk, in contrasting this method of treatment with that of rest, hot vaginal douches, poultices or ice-bags over the inflamed areas, catharsis and anodynes, advocates the vaginal incision as an addition to mere expectancy, and especially the greatly-increased value of incision when made early. The sooner we give exit to the products of inflammation the smaller the damage done to the inflamed area. In these cases the value of the structure involved is so great that the necessity for interference seems unquestionable. The fear of a general peritonitis or extension of infection from the incision is not well-founded, and the early incision is advocated as a routine treatment. If the infection is of a severe type, the incision in the *cul-de-sac* should be extensive, the tubes brought down, and their contents expressed, if possible, through their fimbriated extremities after previously packing sterile gauze above them to protect the peritoneal cavity. The gauze is removed after cleansing the field of operation, and a large perforated drainage-tube fixed in the vaginal opening, which is removed in three days. The primary purpose of the operation is to save the uterine appendages.

B. McE. Emmet: Where the tube is enlarged through the accumulation of pus, he feels much hesitancy in operating by the vaginal route unless the tube can be well brought down, retroverting the uterus, if necessary. In cellulitis involving the cellular tissue of the broad ligament, early operation is advisable to draw off the serum, so as to limit the deposit to serum only.

J. E. Janvrin: If abscesses have begun to form already, or have gathered in the tubes or elsewhere in the pelvis, some operation should be performed, preferably from below, if they are accessible. He treats the acute cases on the expectant plan.

Egbert H. Grandin: Acute cases are treated on the expectant plan, and if an exudate forms, a vaginal incision is made. He has not seen a case where it was necessary to make an earlier incision. He advocates the abdominal route for a radical operation on a pyosalpinx rather than drainage by vaginal incision on account of intestinal adhesions and possible injury to the intestine, or rupture of purulent material into the peritoneal cavity.

Herman J. Boldt: He advocates the vaginal incision in acute pelvic disease, but does not believe in a surgical operation to abort a future ailment. He has had excellent success in draining large exudates and pyosalpinx lying on the pelvic floor, so as to be readily accessible to the vaginal incision.

Henry C. Coe: Great discrimination must be observed in the selection of cases. It is a question how the mild cases which recover under the expectant treatment can be distinguished in the beginning from virulent types which will die in spite of any treatment.—*American Journal of Obstetrics*, March, 1902.

George R. Southwick, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

CONDUCTED BY O. S. HAINES, M.D.,

with the collaboration in German literature of C. Sigmund Raue, M.D.

A CONTRIBUTION TO GYNÆCOLOGICAL HOMŒOPATHY.—The following interesting contribution from Dr. T. F. Allen was read at the meeting of the Central New York Homœopathic Society, June, 1901: A certain lady, who was afflicted with a cancerous growth in her breast, having been advised by her physician to see a surgeon about the matter at once, consulted Dr. Allen instead. She hoped that something might be accomplished by internal treatment that would obviate the necessity for an operation. Dr. Allen examined the woman carefully, sending her also to a gynæcologist for local examination of the pelvic organs. An agreement in opinions was reached that the patient suffered from a *cystocele*. Dr. Allen found by questioning that since the birth of her first child this had persistently protruded. She was much annoyed in a general way by it, and there was frequent necessity to empty the bladder. She also suffered dragging pains from her shoulders downward. Having been recently much interested in Hahnemann's "Original Notes" emphasizing stannum for an atonic condition of the bladder, with symptoms so similar to those produced by a *cystocele*, and finding many of her complaints under the same remedy, Dr. Allen prescribed stannum. He does not mention either the potency nor the frequency of its administration. A great relief was experienced after this remedy has been taken for a short time, and a re-examination by the gynæcologist showed an actual improvement in the local condition. The bladder had improved in tone, was not prolapsed, and in every way seemed better. The gynæcologist was surprised, and stated that she would in the future use stannum internally in those cases which seemed to require a plastic operation for the relief of *cystocele*. Some of our readers will no doubt be wondering, about this time, what became of the cancerous growth in the breast; for which, alone, the patient sought the advice of Dr. Allen. No appreciable results seem to have been attained in that direction, but the lady has grown stronger, and her health has steadily improved, so that the author is hopeful of the entire disappearance of this trouble.

As Dr. Allen says, plastic operations for the cure of *cystocele* are difficult, and are not always fruitful of good results; and so, any drug that promises to relieve or cure such a trouble will doubtless be welcomed by the profession. He recommends one dose daily for a week, then suspension of drug for two or three weeks, followed by its resumption. We think that Dr. Allen owes it to the profession to relate, at some future time, the further progress of this case. We should like to know whether the breast was finally cured, and

whether stannum succeeded in completely removing the cystocele. So far, it is only apparent that the patient improved in general health, and that she suffered less from the symptoms produced by cystocele. The case is too interesting, and there is too much at stake in the interests of our therapeutic law, to leave us with only this much knowledge of the case. If a complete cure results, it will be a triumph for homœopathy in which we shall all rejoice. If the patient is compelled at some future time to submit to operation for removal of breast and cure of cystocele, it will serve as an illustration of the fact that it is necessary to exercise some discrimination in the practice of Homœopathy, as well as in other matters.—*Medical Advance.*

OIL OF SANDALWOOD.—The declining stage. Subacute attacks. Relapsing cases. Overabundance of pus and epithelium in discharge, but few gonococci. The author admits that he gets his best results by combining three or five drops of this oil with two or three grains of salol. (We can speak rather favorably of pellets medicated with the homœopathic tincture of oil of sandalwood.) He does not like methylene blue. It is greatly overestimated. In gonorrhœal infection of the bladder and kidneys, a very serious complication, Dr. Collins has found urotropin of undoubted value. It seems to have more power over pus than over gonococci, hence useful in pus infection of the genito-urinary tract. For his urethral washes, the author prefers permanganate of potassium, protargol, boracic acid, borolyptol; and especially good results have followed the use of Lloyd's hydrastis and pinus Canadensis. He uses the two latter, 1 to 100 or 150, in hot water. This treatment will not appeal to all, but experiences differ; and when one is relating his experiences to others, he must tell the whole truth.

PNEUMONIA IN THE EXTREMES OF LIFE.—Speaking of the extremes of pneumonia in the aged, Dr. M. E. Hanks says that the homœopathic medicament should be placed first in the list of therapeutic agents. And we believe, with her, that, notwithstanding the fact that pneumonia is generally a self-limited disease, a successful issue often depends upon the care and accuracy with which the similimum is prescribed. In the aged, we have several times seen what was apparently an alarming condition give way under the benign influence of a remedy like sulphur 30; prescribed solely upon those general indications which are known to every one as "sulphur indications." But Dr. Hanks does not despise adjuvants, providing they are really that—namely, agents which really assist the remedy to effect a cure. She would have oxygen used from the first, and freely. She aims at keeping the blood well oxygenated, believing that this will assist the whole system in its fight with the disease. Now, there is nothing new in all this, only that we may well repeat such instructions, as they are too often imperfectly carried out in actual work. The oxygen can now be obtained very easily at the druggists, day or night. The necessary apparatus is loaned with each tank. One hundred gallons costs but a trifle; so that there is no excuse for postponing its use until the advent of symptoms such as cyanosis. And so, also, the subcutaneous saline infusion, which, if used early and persistently, will do much towards sustaining the heart. This procedure can be very easily carried out. And it is very easy to nourish the aged pneumonic patient nowadays, thanks to the many excellent peptone preparations at the physician's command. And, after all, it is the careful attention to details that brings success.

TACHYCARDIA AND ITS TREATMENT.—Halbert, of Chicago, points to the fact that tachycardia is a symptom of far greater significance than is usually believed. He meets it nowadays with alarming frequency, and fears that it is often the premonition of a more serious cardiac trouble. His view of the matter is, doubtless, the proper one; and we heartily concur in all that is said upon the subject in April *Clinique*. For instance, when a rheumatic endocarditis has produced sufficient valvular change to prolong and accentuate the systolic sound, we observe first a heart hurry, which antedates the organic change. When a muscular hypertrophy fails to compensate the dilating ventricle, our first sign of warning may be tachycardia. Or when the fatty heart is whipped up by digitalis or glonoin, or when over-exertion shows its first tension, tachycardia is often a bothersome feature. And so, continues the author, in every heart perversion, from angina to the cardiac neuroses, this troublesome sign is a premonition. Sooner or later, the arrhythmia of more serious trouble attends it. The ordinary description of palpitation does not explain it fully. When we look into the etiological factors, we find, as preceding irritations, nervous diseases, psychic disturbances, toxic influences, exhaustive diseases, reflex disturbances, etc.; but, as far as the anatomical alterations are concerned, no one has yet satisfactorily explained them. When he comes to consider the treatment, Dr. Halbert deprecates, first of all, efforts towards heart stimulation. The so-called heart-tonics are the worst possible measures. Our first aim should be the restoration of nerve-cell protoplasm. No better remedies can be found for this than the picrate of zinc and the phosphate of iron. The persistent use of these has worked decided results. Practically, we may find the typical tachycardia in exophthalmic goitre; and here the thyroid enlargement and the tachycardia are the cardinal symptoms of a deep-seated nervous disease. A protoplasmic exhaustion, which may have been of long standing, first manifests the pronounced symptoms of tachycardia, exophthalmus and goitre; but tachycardia always precedes. When we are called to treat this disease, we seek a remedy that suits the three cardinal symptoms; and we may find such a true similitum in the *lycopus virginicus*. We believe we have cured some cases with the *lycopus*. Dr. Halbert explains its curative influences as follows: It regulates the cardiac action without any stimulating or cumulative action. It decreases the blood-pressure in the arteries and relieves undue tension. It sustains the vasomotor function; it establishes a correct peristalsis of the intestines; it allows a proper cell circulation, which insures a protoplasmic increase. It overcomes cardiac irritability. To which we would like to add: It cures the patient because of its homœopathic relationship to the symptoms of the disease as manifested in an individual case. Low dilutions have seemed to be more effective in our hands. We should like to hear something about the action of *lycopus* in the higher dilutions, in exophthalmic goitre, from those who have had success with the higher potencies.

ACUTE GONORRHOEA WITH SPECIAL REFERENCE TO TREATMENT.—Some people think that our specialists pay too little attention to homœopathic therapeutics, and some specialists think that our doctors pay too much attention to the medicinal part of the treatment, neglecting, very often, certain essentials in the direction of mechanical and surgical management. But this lack of unanimity of opinion goes to show a lack of uniformity in the devel-

opment of the discriminating faculty. A doctor with normally developed powers of discrimination never loses sight of the mechanical and surgical needs of his cases; neither will a specialist fail to acknowledge the wonderful power of properly selected internal medicaments, unless he is mentally lopsided. By remembering this, we can avoid heartaches at our Society and Institute meetings. However, this has nothing to do with our present subject, save that Dr. C. D. Collins, in his paper upon Gonorrhœa, written from the standpoint of the specialist, takes pains to mention the fact that while he has searched in vain for something better, he has been compelled to come back to our old, well-proven remedies, and considers them the best the profession affords. Yet he does not neglect the mechanical needs of his cases, and his experience has made him an advocate of urethral washes. His indications are brief, but to the point. He refers to the fact that if a patient reports to us that his discharge began promptly "next morning," after an exposure, he has not contracted anything. That man has probably had a damaged urethra (gonorrhœal or traumatic), and his sudden discharge is only a result of stirring up his latent inflammation or infection, or both. (Too much beer and bustle will sometimes cause an immediate urethral discharge, but it is not gonorrhœa.)

Aconite.—Fever. Agony at the *beginning* of urination. Burning, hot pain in the urethra, with scanty urine. *Belladonna*.—Spasmodic urination, urine comes in drops or spasmodic jets. Posterior urethritis with prostatic complications. In females, the parts are swollen, tender, with feeling of pressure, is characteristic. *Cantharis*.—Posterior urethritis, with *straining* and *bloody* discharge. *Gelsemium*.—The greatest abortive remedy we have. Shortens or aborts a case, if used early. The best remedy to prevent urethritis after instrumentation or operation. Aching, dragging about hips and back. Relapsing gonorrhœas. Sero-pus discharges of small amount in old cases.

AGARICUS MUSCARIUS.—An exhaustive study of the physiological action of agaricus muscarius and its alkaloid muscarin, from the pen of Dr. Krausz-Busch, is found in the *Allgemeine Hom. Zeitung* of Jan., 1902. For the proving of this remedy he gives Dr. von Zlatarovich especial credit.

The action of this poison upon the central nervous system manifests itself in a modification of consciousness; delirium; hallucinations and illusions; intoxication; convulsions and mania; trembling and muscular twitching; vertigo; stupor, and coma. First there is irritation, and then paralysis of the centres. In poisoning cases, a state of pronounced intoxication, with exaltation of the senses and emotions, is followed by prostration and coma.

Like curare, it paralyzes the motor end-plates of striated muscles. Chemically, muscarin is related to the ammonium bases ($C_5 H_{15} NO_3$), and shares the paralyzing effect of these.

The *skin* is specifically affected. Coldness is much complained of, and this is followed by cyanosis of the face and extremities, with cold sweat. Burning and itching, as well as various forms of eruption, have also been observed in the provings. In doses of 3 to 5 mgms. muscarin produces profuse sweating in man and in mammals.

Among the symptoms belonging to the special senses, those of the *eyes* are most prominent. Lachrymation, mydriasis and amblyopia have all been observed. Spasm of the ciliary muscle has also been produced.

In the *ears* there is tinnitus aurium, while the nose seems affected by an acute catarrhal process.

The *temperature* is subnormal in the last stages of the poisoning cases. Provers have recorded "chilliness; shaking chills; coldness of hands, with warm face." According to Carville, small doses cause a rise of temperature, while larger doses depress it.

The toxic effect upon the *heart* is to cause a slow, feeble pulse, with eventual arrest of the heart's action. The heart stops in diastole, through irritation of the intracardial inhibitory mechanism (Schmiedeberg), or, as Dr. Krauz-Busch prefers to believe, in common with Luchsinger, His, and others, through paralysis of the excito-motor apparatus. The primary action, and that obtained from physiological doses, is an acceleration of the pulse rate, probably the result of irritation of the excito-motor apparatus. Large doses also paralyze the heart muscle direct (strophanthus). Atropin is a most active and reliable antidote. It has saved the lives of animals even after a dose five times the usual fatal dose had been administered.

The *blood-vessels* undergo a primary contraction, followed by a paretic relaxation. Blood-pressure is considerably lowered.

The *respiratory acts* become difficult, and there is a tightness of the chest. Stertorous breathing is found in fatal cases. (*Edema of the lungs* is frequently observed in animals that have been poisoned by muscarin. The secretion of the bronchi is much increased.

The symptoms referable to the *gastro-intestinal tract* are characteristic. There is salivation; dryness of the pharynx; thirst; constriction of the throat; nausea and vomiting; pain in the abdomen and rumbling; diarrhœa, with straining and bloody passages; meteorismus.

The *spleen* has been found contracted and irregular in outline.

Urinary organs.—Itching and stitching pains in the urethra; strangury; diuresis.

Strange as it may seem to us, Dr. Krauz-Busch makes no reference to chorea in his *resume* of the therapeutic sphere of agaricus. This is, perhaps, its most useful sphere, after which comes its applicability in typhoid fever, with profound depression of the nervous system, and cardiac debility, especially when primarily dependent upon vasomotor paresis. This condition is particularly encountered in those addicted to the excessive use of alcohol. As its pharmaco-dynamics demonstrate, it is also perfectly homœopathic to night-sweats, in which condition it is most efficacious. Agaricin, which is much used by American homœopaths in preference to agaricus or muscarin, is not derived from agaricus muscarius, but from the white agaric (*polyporus officinalis*). Agaric acid, the pure active principle of agaricin, should be used in preference to the latter (*Merck's Index*). The dose of muscarin is $\frac{1}{30}$ to $\frac{1}{15}$ grain, while that of agaricin is $\frac{1}{4}$ to 1 grain. It is question whether muscarin would not be the better substance to use, as agaricin is not a pure alkaloid, but it would be necessary to employ the muscarin with greater caution, owing to its poisonous properties.

THE TREATMENT OF INFANTILE COLIC.—In that excellent work entitled "*Kinderkrankheiten*," by Dr. Franz Hartmann, the author speaks as follows of the homœopathic remedies that are useful in the colic of infants:

"It is a well-known fact that *chamomilla* is a useful remedy in flatulent

affections of infants. This is known by all aunts, grandmothers and midwives, but they do not realize that the long-continued use of chamomile tea may produce ill effects. Often a few teaspoonsfuls of sweetened black coffee are useful, especially after the abuse of chamomile, and when the pains are associated with feverishness and anguish. *Coffea* 3d potency acts even more rapidly than black coffee.

"If convulsions are added to the above symptoms, *ignatia* 12th is more indicated. When there is nausea, vomiting and diarrhoea, *pulsatilla* should receive preference over the above remedies, while *nux vomica* is indicated when constipation and flatulency are associated. [*Nux vomica* is an excellent remedy in infantile colic when there is distention of the abdomen and continuous straining on the part of the child, with drawing up of the legs and grunting.—C. S. R.]

"In cases where *chamomilla* seems indicated, but fails to relieve, no remedy is more suitable than *colocynthis* 30th potency. *Senna* 3d has proven useful in colic with flatulency, bloody stools, and sleeplessness."

KALI BICHROMICUM IN HAY FEVER.—Dr. Goullon (*Leipziger Populäre Zeitschrift für Homöopathie*) relates a case of hay fever in which the patient complained of "coryza of the most pronounced type, with obstruction of the nose and violent attacks of sneezing." The attacks of sneezing came on in bed, and were so persistent that the patient felt debilitated therefrom. He was a neurasthenic, complained of cold hands and feet, and had been to the seashore, where the symptoms subsided, but on returning home they recurred with full force. *Kali bichromicum* 6th decimal trituration was prescribed, and a cure promptly followed. Dr. Goullon believes this remedy to be strongly indicated where the above symptoms are encountered. Together with these, there is usually a profuse watery discharge from the nose. He recalls having cured a number of other such cases.

MORPHINE IN THERAPEUTICS.—This is the title of a little *resume* of some cases in which Dr. J. C. Kilgour found morphine a very helpful drug. Dr. Kilgour is an eclectic physician. He does not deny that the injudicious use of this agent may be followed by unfavorable results; but, at the same time, he contends that, when used in proper cases, and with caution, it may save life by its quieting influences. We have always thought that the physician's estimate of the value of morphia depended very much upon the sort of cases his experience had brought him. Some men are fortunate, others are constantly brought face to face with complications and conditions which seem to interfere with the speedy effectiveness of the selected remedies. Some men never meet with delirium that refuses to yield to the carefully-selected homœopathic remedy. But we think there are such cases, and that we have seen some of them. Dr. Kilgour has apparently had a few himself. And, he is glad that he can command such an effective agent as morphine in such cases. One of his cases was a girl, aged ten years. In the third week of her typhoid, a talkative delirium came on. It prevented sleep, refused to yield to remedies given, and threatened to wear her out. One-eighth grain of morphine, repeated upon three evenings, cleared up her mental condition, and a good recovery followed. A boy, aged eight, had pneumonia; in this case the pain in the chest was so severe, the breathing so short and difficult, the fever and delirium so marked, that the author gave one dose of morphia.

The prompt relief afforded by this drug demonstrated the correctness of the physician's reasoning. Then, he mentions the case of a young married woman who had a septic fever after an abortion. She was wildly delirious, and had a temperature of 105 degrees. After the administration of quarter-grain morphia, temperature fell 2 degrees, and she became quiet and rational. Probably his most striking results were obtained in some cases of delirium tremens. The men were wild, grasping at flocks, leaping out of bed, fighting with the nurses, unable to eat or sleep. After complete failure of other remedies, the hypodermatic use of morphia, quarter-grain dose, brought complete relief. After this, careful feeding soon restored them to their normal states. These are therapeutic facts that are worthy of contemplation. Of course, it is permissible to submit that, in just such cases as those mentioned, the homœopathic materia medica offers the physician many remedies fully as effective as either chloral, the bromides, or even morphine. But the fact must remain that occasionally a case will be seen that refuses to yield to any drug but morphia.—*Eclectic Medical Journal*.

PARTICULARIZATION IN TYPHOID FEVER.—The author of this paper says truly that homœopathy has a decided advantage over other forms of medical practice in the treatment of typhoid fever; in its power to specialize, particularize and individualize its cases in the selection of remedies, and their application at the bedside. This should be accounted a very strong argument in favor of our method of therapeutics in this day of specialization in all departments of medicine and surgery. And it seems odd that any practitioner who is familiar with the homœopathic method of therapeutic specialization would wish to revert to the old-fogy method of making all cases of typhoid call for a certain drug or line of treatment, whether they will or not. There is no disease that calls more urgently for individual recognition in therapeutics than typhoid fever—no disease in which the physician must pay greater attention to the individual needs of each case, if he would secure the best possible results. Therefore we say, Dr. Fisher's words ring true when he says: "Routinism in typhoid is little short of criminal." We cannot always follow him in his further arguments, however, as when he says: "Rarely, if ever, should an acute medicine be given as a first prescription." He thinks it better to begin each case with that patient's constitutional similitum. He follows Allen, who believes that typhoid is but a volcanic outbreak of some constitutional miasm. These observers would have us begin the treatment of every case of typhoid fever by such antipsorics as sulphur, calcarea, psorinum, iodine or tuberculinum, prescribing them especially upon the constitutional peculiarities which are supposed to picture a sulphur or a calcarea individual, for examples. We are to give the constitutional remedy in a single dose and wait. We cannot agree with our author when he says there is no hurry in typhoid fever. In our opinion, much depends upon the promptness and vigor with which the therapeutic assault is made during the first week of the disease. But we agree that strict individualization is essential in the selection of the drug, which does not mean, necessarily, that it be an antipsoric that is chosen. And, again, we must not forget that much also depends upon strict particularization in regards to nursing and diet. Yes, routinism is here little short of criminal; even routinism to the extent of always neglecting the acute manifestations of disease, and focusing one's mental gaze upon some far-distant hereditary taint, or some constitutional predisposition.—*May Advance*.

ICHTHYOL.—In a recent proving of this drug, made by the Alpha Sigma members of our New York College, it was shown that ichthyol should have a prominent place in the therapeutics of the uric acid diathesis. Lithæmia was indicated by the urinary provings, and should prove amenable to the remedy, given in potency. Hay-fever symptoms were also prominent in this proving, and its application in this intractable affection is awaited with interest. The lachrymation, coryza, and dry, teasing cough of measles seem also well pictured. Whooping-cough, tonsillitis, and the tiresome, intractable coughs of the aged suffering from bronchial affections, would also appear to offer us a chance for the trial of this new remedy. The symptoms are well described in detail in the article mentioned, and should be consulted. The remedy acts especially well in some dry, hacking coughs. The 3x, 6x and 8x potencies are suitable forms for its administration.—*The Alpha Sigma.*

DO HOMEOPATHS NEED ANTITOXIN?—Evidently Dr. C. E. Fisher does not, if we may judge from his article upon that subject in the *May Journal of Pediatrics*. He speaks very emphatically against it; and claims that it is a fact, although the profession seems not to generally know it, that it is the deep-acting, pedigree-hunting, dyscrasia-destroying remedies that do the best work in diphtheria, as in all profound diseases. A dose of tuberculinum, or sulphur, or calcarea, or iodine, in high potency, according to the constitutional state of the patient, is very often the one thing needful to set the patient going right, in diphtheria, in typhoid fever, or in pneumonia. Then the local throat symptoms will respond better to remedies prescribed for them than previous to the stirring of his systemic responsiveness. The antitoxin question has been very quiet, lately.

REMEDIES IN DISTURBANCES IN THE SECRETION OF THE BILE.—Dr. Donner (*Homeopathische Monatsblätter*, Marz, 1902) contributes an interesting paper upon hepatic affections, and points out the clinical importance of distinguishing between the light stools resulting from catarrh of the duodenum and biliary ducts, and those from grave hepatic disease in which there is degeneration of the hepatic cells. In the first class of cases chelidonium, bryonia, leontodin and mercurius corr. are indicated, and in the latter classes lachesis, naja, phosphorus and arsenicum. He states that often we trifle away valuable time with the first class of remedies in the graver form of hepatic insufficiency, when some good might have been done by using the deeper acting remedies. This is a clinical lesson which deeply emphasizes the importance of taking pathology into consideration in determining upon the proper mode of treatment for a given case.

A STUDY OF ARNICA MONTANA.—Dr. Richard Haehl (*Homeopathische Monatsbl.*), in a study of the symptomatology of arnica montana, considers the following four spheres of action the keynotes to a proper understanding of the drug:

Firstly, it induces severe pains, as if a contusion or bruise had been sustained. Every portion of the body, but especially the muscles, feel as if beaten. Joint pains develop, as if after violent overexertion or sprains.

Secondly, arnica affects the venous system, inducing stasis, ecchymosis and hæmorrhage.

Thirdly, diarrhœa is induced. Even small doses will induce frequent, dysenteric stools, accompanied with muscular pains. (Compare baptisia.)

Fourthly, arnica produces a train of febrile symptoms closely related to typhoid fever.

THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER.

A Medical Newspaper.

EDITED BY

HERBERT P. LEOPOLD, M.D.

JUNE, 1902.

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Quain's Dictionary of Medicine. By various writers. Third edition, largely rewritten and revised throughout. With fourteen colored plates and numerous other illustrations. Edited by H. Montague Murray, M.D., F.R.C.P. Joint Lecturer on Medicine, Charing Cross Medical School, and Physician to Out-patients Charing Cross Hospital, etc.; assisted by John Harold, M.B., B.Ch., B.A.O., Physician to St. John's and St. Elizabeth's Hospital for Children, Chelsea, etc. New York: D. Appleton & Co. 1902. Price, \$10.00.

In preparing the new edition of this Dictionary, the editor's object has been to produce a book which shall serve as a reliable and readily available work of reference for the practitioner and student of medicine.

The general scheme of the book—so skilfully planned by the late Sir Richard Quain—has been preserved, and the special emphasis laid on the diagnosis and treatment of disease has been maintained, although the pathology and etiology have also been very carefully considered and revised. Many articles—excellent in themselves, but not in accord with the special object in view—have been omitted, while repetitions have been, as far as possible, excluded. It has thus been found practicable to include a large number of new articles, rewrite many others, and yet to publish the Dictionary in one volume. The recent and ever-increasing incursions of surgery into the realm of medicine have received adequate recognition, and more space has been allotted to what are generally known as special branches. A large number of cross-references have been inserted in order to bring under the notice of the reader articles giving further information on the various subjects.

The Operations of Surgery. By W. H. A. Jacobson, M.Ch., Oxon., F.R.C.S., Surgeon to Guy's Hospital; Consulting Surgeon, Royal Hospital for Children and Women; Member Court of Examiners, Royal College of Surgeons, etc.; and F. J. Stewart, M.S., London, F.R.C.S., Assistant Surgeon Guy's Hospital, and to the Hospital for Sick Children; Surgeon in Charge of the Throat Department, Guy's Hospital. Fourth edition, revised, enlarged and improved. 550 illustrations. Two volumes: Volume I. Operations on the Upper Extremity; Operations on the Head and Neck; Operations on the Thorax. Volume II. Operations on the Abdomen; Operations on the Lower Extremity; Operations on the Vertebral Column. Published by P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia. 1902.

The authors state specifically that this work is not intended for persons of large surgical experience, but simply for the aid of those who have been recently elected to hospital appointments, and those who were working for the higher examinations. We might add, also, that it will prove invaluable for general practitioners who are, by force of circumstances, obliged to do their own surgery by reason of their distance from the great medical centres. Necessarily, then, the text describing the different operations is full of the minutest details as to procedures, and is amply illustrated.

The arrangement of subjects is "regional," *e.g.*, Part I. deals with the first surgery of the upper extremity; Part II. of the surgery of the head and neck, and so on. Then each "Part" is further subdivided into chapters, *e.g.*, operations on the hand, operations on the wrist, etc. While this arrangement may be criticized by some, it is a most excellent one from a practical standpoint, as it enables the surgery of the parts to be studied in conjunction with the anatomical points involved.

Jacobson's Surgery has been popular in the past; the quality of information presented in the fourth edition is a guarantee that it will continue to hold a high place in the opinions of physicians.

The Principles of Bacteriology. A Practical Manual for Students and Physicians. By A. C. Abbott, M.D., Professor of Bacteriology and Hygiene and Director of the Laboratory of Hygiene, University of Pennsylvania. Sixth edition. Enlarged and thoroughly revised. With 111 illustrations, of which 26 are colored. Lea Brothers & Co. Philadelphia and New York. 1902.

In preparing this book the author has kept in mind the needs of the student and practitioner of medicine, for whom the importance of an acquaintance with practical bacteriology cannot be overestimated. It is to advances made through bacteriological research that we are indebted for much of our knowledge of the

conditions underlying infection, and for the elucidation of many hitherto obscure problems concerning the etiology, the modes of transmission, and the means of prevention of infectious diseases.

The few years which have elapsed since the appearance of the fifth edition have been particularly fruitful in works of bacteriological interest. Light has been shed upon the etiology of several important diseases of man, notably epidemic cerebro-spinal meningitis and dysentery. Interest has been re-awakened in the subject of tuberculosis; we have all been made familiar with a group of micro-organisms in certain ways allied to bacillus tuberculosis: and having the property of causing conditions more or less suggestive of tuberculosis, and much of fundamental importance has been contributed to our understanding of the mechanism of infection and immunity. Wherever appropriate to a book of this character, these advances have been included.

Of necessity, the book has increased a little in size, but this will in no way detract from its value, nor will it lessen the cordial reception given the preceding editions.

The Therapeutics of Fevers. By H. C. Allen, M.D. Boericke & Tafel, Philadelphia. 1902.

This is an excellent monograph of some 500 pages upon the treatment of the various fevers by homœopathically indicated medicaments. The author has arranged his volume in three parts. First, there are chapters upon the etiology of the various fevers, the psoric diathesis, the examination of a fever patient, the genus epidemicus. Then we are told when to administer our chosen remedy, and this is followed by interesting remarks relating to the potency, relapses and sanation. The main body of the work consists of the partial pathogeneses of some 133 remedies, in which, by a judicious use of three kinds of type, the characteristics, relationships, aggravations and ameliorations, symptoms of the different stages of fever, chill, sweat and apyrexia, are made very clear and plain to the reader. And, finally, at the end of the book may be found a capital repertory. By the use of this latter, the search for the similitum in the foregoing will be made less difficult. The book was written by a homœopath with a dominating faith in the truth of our law of similia. In the earlier chapters he ignores some of the most important results of modern scientific research in typhoid and malarial fevers. And we do not think that homœopaths can do this without loss to themselves. A great deal has happened in both medicine and surgery since the time of Hahnemann. Dr. Allen does not think that large doses of quinine will cure malarial affections. He believes, for instance, that we may cure all our cases of intermittent fever by the similar remedy; and, more than this, he thinks that we should do so. He points out the method of doing this; in fact, has very materially lessened the difficulties that stand in the way of a successful homœopathic prescription for a malarial case. And he deserves the gratitude and thanks of the profession. It now remains for us to thoroughly test the truth of his theories and statements at the bedside. Dr. Allen's book is one that should appeal strongly to every homœopath.

Progressive Medicine. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., assisted by H. R. M. Landis, M.D. Vol. I. March, 1902. Lea Brothers & Co., Philadelphia and New York.

The latest volume of this admirable Digest fully sustains its reputation. The system pursued, that of allotting to the specialist the task of preparing a *resume* of the advances of each department of medical knowledge, has resulted in a series of articles far superior to those found in the average "Annual"

or similar retrospect. To the present volume Charles H. Frazier contributes an article dealing with the surgery of the head, neck and chest. Frederick A. Packard discusses the infectious diseases, and includes under that title rheumatism, the bacteriology of which is attracting so much attention at present. An interesting account is given of the American investigations whereby the conveyance of yellow fever has finally been traced to a variety of mosquito, the *Culex fasciatus*. A chart illustrating the practical disappearance of yellow fever from Cuba affords striking evidence of the success of modern prophylactic methods. Floyd M. Crandall discusses the diseases of children, including the pathology of the newborn, their nutrition and hygiene, and the eternal question of infant feeding. Pathology is ably reviewed by Ludvig Hektoen, who records the knowledge already secured by physiological chemistry in its study of immunity, hemolysis, etc. The advances in bacteriology and pathological histology are reported, and tumors and their alleged causes receive the attention which is their due. St. Clair Thompson writes entertainingly and at some length on laryngology and rhinology, and the volume concludes with a review of Otology by Robert L. Randolph. It is probable that no publication issued succeeds so well in keeping the medical scientist abreast of the times as does the series of which this volume represents an issue.

A Reference Handbook of the Medical Sciences. Embracing the entire range of Scientific and Practical Medicine and Allied Science. By various writers. A new edition, completely revised and rewritten. Edited by Albert H. Buck, M.D., New York City. Volume IV. Illustrated by chromo-lithographs and 859 half-tone and wood-engravings. New York: William Wood & Co. 1902.

This volume fully maintains, if it does not excel, the standard set by the preceding volumes. To review, even superficially, the many fine articles making up the 872 quarto pages is a manifest impossibility. One cannot even hint at all of them. As we have said in previous numbers, the "Handbook" is really a collection of monographs, prepared by standard authorities. In Volume IV., those of especial importance treat of the Eye, Food and Drug Inspections, Diseases of the Feet, Fractures, the Gall-bladder and its Diseases, Gonorrhoea, Gynecological Examinations, Diseases and Injuries of the Hands and Fingers, Hay Fever, Heart Diseases and Hernia. To sum up, every conceivable subject embraced alphabetically between Erg. and Inf. is herein presented. Notwithstanding these words of praise, the reviewer feels that he cannot appreciate the full value of this stupendous work until the eighth, and concluding volume, with its index, will have been issued.

International Clinics. A quarterly of illustrated Clinical Lectures and especially-prepared articles on Medicine, Surgery, Neurology, Therapeutics, Obstetrics, Pediatrics, Pathology, Dermatology, Diseases of the Eye, Ear, Nose and Throat, and other topics of interest to students and practitioners. By leading Members of the Medical Profession throughout the world. Edited by H. W. Cattell, A.M., M.D., Philadelphia, U. S. A., with collaborators and correspondents in Montreal, London, Paris, Leipsic and Vienna. Volume I. Twelfth series. Philadelphia: J. B. Lippincott Co. 1902.

The value of a book is that of the information to be obtained from it. We are led to this remark after reading the article by Dr. Simon, of Johns Hopkins University, on "The Significance of Basophilic Granules," with special reference to their occurrence in chronic lead-poisoning. Of especial importance is the description of a new method of blood-staining; that is, by means of the eosinate of methylene blue. The film requires no preparation other than

drying in the open air, and the result is equal, according to the author, to the slides prepared by the Ehrlich tricolor stain. That our author has not written prematurely is assured by the fact that he has now been using the eosinate of methylene blue regularly for three years. We express, as our opinion, that should the "Clinics" contain nothing else of value for the balance of the current series, the information obtained by the reader from this article alone is worth the price of the four volumes.

But the merits of this number of the "Clinics" are not confined to Dr. Simon's paper. Dr. Meigs's remarks on the "Use of Opium in Daily Practice" will appeal to many as of great practical value. Dr. Boas's "Habitual Constipation" will interest every practitioner. We find, also, articles for the surgeon, the obstetrician and the aurist. The volume closes with a general *resumé* of the advance of medicine during the year by Edward Willis Watson.

Saunders' Medical Hand-Atlases.—Atlas and Epitome of Operative Surgery. By Dr. Otto Zuckerkandl, Privatdocent in the University of Vienna. From the second revised and enlarged German edition. Edited, with additions, by J. Chalmers Da Costa, M.D., Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College, Philadelphia, etc. Second edition, thoroughly revised and greatly enlarged. With 40 colored plates, 278 text illustrations, and 410 pages of text. Philadelphia and London: W. B. Saunders & Co. 1902. Cloth, \$3.50 net.

This excellent work needs no further recommendation to English-speaking readers than its author's name—Dr. Zuckerkandl. The rules and methods of surgical procedure are stated with the clearness that springs from definite knowledge and the emphasis born of conviction. The operations of modern surgery are described lucidly and tersely, making the book a worthy guide alike to the student and the practicing surgeon. The verbal descriptions are most accurately reinforced and illuminated by a large number of original colored lithographic plates and text cuts.

In this new edition the work has been brought precisely down to date. The revision has not been casual, but thorough and exhaustive, the entire text having been subjected to a careful scrutiny, and many improvements and additions made. A number of chapters have been practically re-written, and of the newer operations, all those of special value have been described. The number of illustrations has also been materially increased. Sixteen valuable lithographic plates in colors and sixty-one text figures have been added, thus greatly enhancing the value of the work. There is no doubt that the volume in its new edition will still maintain its leading position as a substitute for clinical instruction.

Saunders' Medical Hand-Atlases.—An Epitome of Otology. By Gustav Bruhl, M.D., of Berlin, with the collaboration of Prof. Dr. A. Politzer, of Vienna. Edited, with additions, by S. MacCuen Smith, M.D., Clinical Professor of Otology, Jefferson Medical College, Philadelphia. With 244 colored figures on 39 lithographic plates, 99 text illustrations, and 292 pages of text. Philadelphia and London: W. B. Saunders & Co. 1902. Cloth, \$3.00 net.

This excellent volume, the first attempt, to our knowledge, to supply in English an illustrated clinical handbook to act as a worthy substitute for personal instruction in a specialized clinic, is, indeed, a magnificent addition to Saunders' Series of Medical Hand-Atlases.

The work is both didactic and clinical in its teaching, the latter aspect being especially adapted to the students' wants. A special and highly commendable

feature is the very complete exposition of the minute anatomy of the ear, a working knowledge of which is so essential to an intelligent conception of the science of otology. As in all this series of atlases, the illustrations are beautifully executed in colors, and illuminate the text in a singularly lucid manner, portraying pathologic changes with such striking exactness that the student should receive a deeper and more lasting impression than the most elaborate description could produce. Further, the association of Professor Politzer in the preparation of the work, and the use of so many valuable specimens from his notably rich collection, especially enhance the value of the treatise. The work contains everything of importance in the elementary study of otology, and, without question, is a most valuable contribution to medical literature.

The New Journal of the Alpha Sigma Fraternity.—We have lately received the first number of the official publication of the Alpha Sigma Fraternity, "*The Alpha Sigma*." This is a quarterly, the pages of which are to be devoted to the propagation of the interests of this band of wide-awake, vigorously growing young medicos, many of whom, we prophesy, will be heard from later, in connection with some important happenings in the homœopathic school. Seven Chapters have already been organized in as many homœopathic colleges, so that the influence of this Fraternity extends now from Maine to California. Beta Chapter, the second in order of installation, was organized in "Old Hahnemann of Philadelphia," in 1897, and numbers among its membership some of the brightest of our boys. Dr. Julian Adair was president of Beta during the years 1901 and 1902. While it is, apparently, not the purpose of this publication to pose as a full-fledged medical journal, but rather as the bearer of news of mutual interest to all the members of the different fraternities, we shall be surprised if some excellent papers do not occasionally slip into its pages, from the fertile pens of some of the frats. Indeed, in this first number may be found a proving of "ichthyol," which was made by the members of Alpha. In this proving, some very interesting facts were brought out, relating to the therapeutic value of the drug in the uric acid state and in hay-fever. These have been referred to in our Monthly Retrospect. We hope *The Alpha Sigma* may live long and prosper in the land of homœopathy.

New York Letter.—A regular meeting of the New York Homœopathic Materia Medica Society was held on Wednesday evening, April 16th, at the residence of the President, Dr. Walter Sands Mills, 154 West 119th Street. "Cantharides" was discussed by the following members: Dr. M. W. Van Denburg, who emphasized his use of the drug in certain cases of dysentery in children; Dr. H. M. Dearborn, diseases of the skin; Dr. J. Hutchinson, diseases of the thorax with anuria or dysuria; Dr. W. H. Dieffenbach, pompholyx and case of burn; Dr. Chas. Ver Nooy, urethritis; Dr. W. S. Mills, cystitis and pyelitis; Dr. E. D. Simpson, albuminuria; Dr. G. F. Laidlaw, history of introduction of cantharis and its therapeutic uses two hundred years ago.

Metropolitan Hospital.—At the last meeting the following physicians were elected to the Auxiliary Board: Drs. E. P. Swift, Chas. Ver Nooy, P. C. Thomas, F. C. Miner, S. K. Royal. Neurologist, Dr. C. C. Howard; Electrician, Dr. W. H. Dieffenbach.

After the competitive examination for internes, the following candidates were recommended for appointment: Drs. S. B. Wakefield, S. H. Brown, J. M. Hanna, James D. Scofield, G. A. Strader, and M. H. Newmiller, Hahnemann, Phila.; Drs. F. I. Nichols, M. G. Chambers, D. O. Norton, and C. M. Dodd, N. Y. Hom. Med. College and Hospital; Dr. E. F. Warner, University of Minn.; Drs. F. R. Sedgely and A. B. Webster, Jr., Boston University.

There will be four more vacancies for internes on December 1st, for which a competitive examination will be held early in October.

Dr. J. T. O'Connor has removed his office to No. 7 West 42d Street.

Dr. Chas. S. Macy has removed to 103 West 71st Street.

Dr. Herbert C. Allen has removed to 304 Clermont Ave., Brooklyn.

Alumni Day, New York Homœopathic Medical College and Hospital, with Commencement, was observed May 8th. The programme was as follows: Introductory remarks by Wm. Tod Helmuth, M.D.; *Materia Medica Clinic* (Three essentials for a Prescription), Geo. Royal, M.D., Des Moines, Iowa; *Surgical Clinic*, Wm. F. Honan, M.D., N. Y. City; *Materia Medica* as applied to surgery, W. A. Dewey, M.D., Ann Arbor, Mich.; *Clinic with the Actinic Rays*, Wm. H. King, M.D., N. Y. City; Luncheon in the College Museum; Commencement Exercises at Mendelssohn Hall; Business Meeting of Alumni Association and Alumni Dinner at Delmonico's.

The following men received the degree of Doctor of Medicine: Jos. H. Beattie, Nathan E. Broder, L. R. Boynton, Merritt G. Chambers, Wm. F. Fowler, Arthur H. Hardy, Thos. S. Hicks, David B. Jewett, Christian H. Mersheimer, Dana O. Norton, Frank I. Nichols, Richard S. Pearse, Audley V. Quick, Emerson W. Rude, Arthur H. Richardson, Warren C. Daly, Leroy E. Franklin, Edouard S. Lovzeaux, Roger W. Moister, John A. Payne, V. Sadashir Zengshe, Otis M. Wiley, Chas. E. Wetton.

Dr. Hardy won the first faculty prize and Dr. Beattie the second. Each prize was a fine microscope. Mr. Eccles received the Fiske prize for highest junior standing.

The Alumni Association elected the following officers for the ensuing year: *President*, E. H. Linnell, '76, Norwich, Conn.; *First Vice-President*, Geo. R. Stearns, '78, Buffalo, N. Y.; *Second Vice-President*, Jas. W. Ward, '83, San Francisco, Cal.; *Third Vice-President*, A. M. Haight, '79, White Plains, N. Y.; *Executive Officer*, Chas. Deady, '76, New York; *Treasurer*, W. G. Crump, '95, New York; *Recording Secretary*, A. W. Palmer, '83, New York; *Corresponding Secretary*, W. S. Mills, '89, New York; *Necrologist*, F. C. Bunn, '89, Orange, N. J.; *Alumnus Trustee*, W. M. L. Fiske, '64, Brooklyn; *Board of Directors*, G. W. McDowell, '86, New York; H. W. Paige, '84, New York; W. B. Winchell, '86, Brooklyn; C. C. Howard, '84, New York; J. P. Seward, '93, New York; Irving Townsend, '87, New York.

At the Alumni dinner the invocation was by Rev. Dr. Chas. H. Babcock. The president, Dr. John L. Moffat presided, and Dr. Bukk G. Carleton was toastmaster. Following were the toasts: Hahnemann, the scientific physician (In silence). The Alumni of the N. Y. H. M. C. & H., Wm. Tod Helmuth, M.D., LL.D. The upward pressure, Mr. Augustus Thomas. While we live let us live, Rev. Dr. Chas. H. Babcock. Medicine and the Drama, Mr. Marshall P. Wilder. The Family Physician, Dr. T. Y. Kinne. The Class of 1902, Dr. Merritt G. Chambers.

The New York County Society meeting was held at Carnegie Hall on Monday evening, May 12th. Candidates elected to membership, reinstatement, honorary membership and corresponding membership numbered twenty-eight. Reports were presented in memory of the late Eloise I. Church, M.D., by a special memorial committee, consisting of Drs. A. Lenora White, Sophie B. Scheel, and John W. Dowling, and by the necrologist, Dr. J. Hutchinson. The committee on obstetrics presented a paper by Louise Z. Bucholz, M.D., entitled "A Complicated Pregnancy," which was discussed by Drs. S. F. Wilcox, A. Lenora White, Elizabeth Jarrett, and F. W. Hamlin. Committee on women and children presented a report, "Infantile Insanity," by John Hutchinson, M.D.; discussed by Drs. John E. Wilson, G. F. Laidlaw and E. D. Simp-

son. Owing to the late hour, report of the materia medica bureau was postponed.

The dinner given in honor of Dr. Selden H. Talcott to commemorate his twenty-five years of service as Medical Superintendent of the Middletown State Homœopathic Hospital, on the evening of May 14th, at the Waldorf-Astoria, was largely attended, and proved a delightful occasion. Toastmaster, Dr. Clarence W. Butler, of Montclair, N. J. Dr. A. P. Williamson, of Minneapolis; Dr. John E. Wilson, of New York; John W. Slauson, Esq., of Middletown, N. Y.; Dr. A. E. McDonald, of Manhattan State Hospital; Dr. N. Emmons Paine, of West Newton, Mass.; Dr. G. W. Roberts, of New York, and Dr. Talcott were the speakers of the evening, the latter also receiving a beautiful loving-cup.

The thirty-ninth annual commencement of the New York Medical College and Hospital for Women was held on Wednesday evening, May 14th, in the Astor gallery at the Waldorf-Astoria. Dr. Mary E. Butterworth, Dr. Mary C. Pearson, Dr. Jane H. Sutherland, Dr. Anna M. Novenski, Dr. Eleanor L. Rundio and Dr. Daisy I. Whittemore were the class of 1902, and the prizes were secured by Drs. Sutherland and Pearson. The Alumnae dinner of the Women's College was held on the evening of May 15th, at the Hotel Majestic. The guests numbered one hundred and fifty.

The sudden death of Dr. Wm. Tod Helmuth, on May 15th, has cast a heavy gloom over the profession at large, and particularly those members of it who have long been associated with Dr. Helmuth in the larger medical organizations.

John Hutchinson, M.D.

Married.—Mr. Robert C. Atkinson announces the marriage of his daughter Maybel Zell to Dr. J. Wyllis Hassler, Wednesday, May 7th, 1902, Philadelphia, Pa.

Died.—Dr. Frank R. Schmucker, aged 64 years, one of the oldest homœopathic practitioners in Reading, Pa., is dead. Dr. Schmucker was graduated from Yale College and the New York Homœopathic College. Previous to studying medicine he was a member of the Berks county bar. He was also a veteran of the Civil War.

A Golden Wedding.—On Wednesday afternoon, April 16th, at the home of Dr. N. Emmons Paine, of Newton, Mass., the golden wedding of his parents, Dr. and Mrs. Horace M. Paine was celebrated. They were married fifty years ago in Norfolk, Mass., at the home of the bride's father, who was an influential old settler there. Thomas Paine came over from England in 1637 and was one of the early settlers of Salem. His will was the eleventh to be probated there. About 30 relatives were present Tuesday, all descendants of the parents of Dr. and Mrs. Horace M. Paine. A wedding breakfast was served at one o'clock, the party going to the dining-room accompanied by the strains of the Lohen-grin wedding march.

Personal.—Jos. J. Kinyoun, M.D., Ph.D., late Surgeon of the Marine Hospital Service, and Director of the Hygienic Laboratory at Washington, has assumed the Directorship of the Biological Laboratories of the H. K. Mulford Company, at Glenolden, Pa.

Dr. C. S. Raue announces his removal to 1621 Chestnut Street. Diseases in Children.

Dr. W. D. Culin has removed to 708 N. Fortieth Street.

Dr. Chas. H. McDowell has removed from 1121 to 1029 Shackamaxon Street.

Dr. H. Croskey Allen has located at 1210 Locust Street. Diseases of the stomach.

Drs. Bayley, Haines and Mercer have just returned from an ocean trip to Boston.

Dr. Wm. Tod. Helmuth, dean of the New York Homœopathic College, died May 15th.

A Banquet to Dr. Selden H. Talcott.—A banquet was given by the homœopathic medical profession to Dr. Selden H. Talcott at the Waldorf-Astoria, New York City, Wednesday evening, to commemorate his twenty-five years' service as Superintendent of the Middletown State Hospital. About 150 were present at the banquet, which was served in one of the ball-rooms of the hotel.

The guests were seated at small tables, while at one end of the room was a long table at which were Dr. Clarence W. Butler, of Montclair, N. J., who presided, Dr. Talcott, and the speakers of the evening.

Dr. N. Emmons Paine, of West Newton, Mass., a former assistant at the Middletown Hospital under Superintendent Talcott, presented the doctor with a book of letters which had been bound for preservation. They were from well-known physicians, and were letters written in regard to commemorating Dr. Talcott's anniversary. Extracts were read from several, among the number that of Dr. H. R. Stiles, who was superintendent of the hospital from 1874 to 1877, and who was succeeded by Dr. Talcott. All contained warm expressions of congratulations and appreciation of Dr. Talcott. Each letter is inlaid on a large sheet.

Dr. Wm. Tod Helmuth, Dean of the New York Homœopathic Medical College, who was to have been the last speaker, was detained at home by illness, and Dr. Geo. W. Robertson, of New York, was substituted. As he concluded his remarks he presented on behalf of the subscribers to the dinner a handsome loving-cup as an emblem of respect, regard and love.

Dr. Talcott was received with great enthusiasm as he rose to respond and to accept the two gifts. When he could be heard, Dr. Talcott, whose voice was choked with emotion, delivered an eloquent address as follows. He said, in part :

Mr. Chairman and Gentlemen.—I wish to thank you for the high honor which you have conferred upon me to-night, for your beautiful present, for the warmth of your greeting, and for your flattering words of appreciation. I feel

"Like him who, in the old, Arabian joke,
A beggar slept and crowned Caliph woke.
Thanks not the less. With not unglad surprise
I see my life-work through your partial eyes;
* * * * *
You do but read between the written lines
The finer grace of unfulfilled designs."

A quarter of a century ago, we commenced our task of applying homœopathic treatment for the cure or relief of the insane. This method had already been exemplified by the illustrious founder of our school at Georgenthal, near Gotha, in Saxony, more than a century ago. The proving of various drugs in materia medica developed the fact that mental symptoms came out prominently, and therefore it was reasonably concluded that the powers of homœopathy might exercise a vast and mighty influence in the relief and cure of those who were afflicted with mental disorders.

The experiment of establishing and maintaining a homœopathic hospital has seemed to meet with a reasonable amount of success. Six thousand patients have been treated at Middletown. Between two and three thousand have been discharged recovered. Forty-six per cent. of those discharged have returned to their homes with renewed health.

The following resolution complimentary to Dr. Selden H. Talcott of the Middletown (N. Y.) State Homœopathic Hospital was unanimously adopted at the Thirty-Fourth Annual Meeting of The Homœopathic Medical Society of Kansas, in session at Topeka on May 7, 8 and 9, 1902.

WHEREAS, Dr. Selden H. Talcott has devoted his life-work to the cause of homœopathy in the treatment of the insane, and has just completed the twenty-fifth year of service as superintendent of the Middletown (N. Y.) State Homœopathic Hospital, thereby ennobling the cause and advancing the school so as to command the recognition not only of our adherents, but of the entire medical profession of the world;

Therefore, In appreciation of this fact, The Kansas State Homœopathic Medical Society congratulates Dr. Selden H. Talcott upon his successes, and felicitates the profession and the people of the State of New York for having this eminent man in their midst.

Hahnemann Medical College and Hospital Commencement.—The fifty-fourth annual commencement of the Hahnemann Medical College and Hospital took place Thursday evening, May 15th, at the Academy of Music. The music was furnished by the Germania Orchestra, under its able conductor Mr. Wm. Stoll, Jr. The entrance of the Trustees, Faculty and Graduates was greeted with applause by the audience. The opening prayer was offered by Rev. G. Roland Hill, B.D., of the Church of the Holy Apostles. The address was delivered by the Rev B. L. Whitman, D.D., LL.D., formerly president of Columbian University, and was as follows:

Did you ever feel relieved? When I looked at the program and read "persiflage," I thought Dean Dudley had chosen that theme as the subject of my address, and it has taken me all this time to find out that it was the orchestra, and not I, who would entertain you with "persiflage."

It is a pleasant fiction that the college graduate is just hungry for advice. We older men are very careful to encourage the fiction, for without some such fiction some of us would never get a chance on a commencement program. I suppose there is a measure of reason in the thought that men will listen, knowing that they are so soon to be relieved, and it thus comes out that a man is wonderfully responsive when he feels at last the tugging at his heart-strings when this last evening comes, and we begin to realize that college fellowships in one form are about to be broken up. It is altogether likely, therefore, that we are minded, with all our jesting, in this hour to take commencement hours somewhat seriously.

The first word I want to say to you is that Nature seems concerned to help you. If I were going to ask these gentlemen, as they face their professional career, to show true diligence in the discharge of their office, I would simply be putting into words what all Nature seems to be compelling or attempting to compel them to do. There never has been a time in the world's history when it was so dangerous as at this day for a man to attempt to make his way on the strength of some other man's name. It is probably a part of the order of things that every man in this world shall find his own footing. The corn-crackers of the lower Mississippi sit on the fences shaking with ague and discussing the question why weeds will grow so much faster than crops. Mark Twain says the ague is a merciful provision of Providence to give them exercise. It seems to be a merciful provision that Providence sees to it that we do not stagnate. A man is shaken up and shaken down, until, placed where he belongs, he is made to understand why a merciless Providence would not let him rest. Down east they have an expression which I have never heard used elsewhere. You know when a man gets to work he always has a lot of sympa-

thizers who encourage him by standing around and making suggestions. Down east they speak of these sympathizers as "doing the heavy work of looking on." An amazingly large number of men are fitted by inclination and training to "do the heavy work of looking on," and this type is not found among the uneducated alone. The scholastic product is manifold, some of it wholly unbeautiful and practically worthless. There are three forms that illustrate this: the social nonentity, the physical abortion, and the intellectual monstrosity. Whom do I mean when I speak of the social nonentity? The sort of manhood that consists of a lot of clothes with a hat stuck on top. The physical abortion is the physical giant who takes an eighteen and a half collar and a six and a half hat. The intellectual monstrosity is the man who is all brain with no body to support it, and who goes up and down the world an underfed, walking ghost. All such have to be placed or displaced, so that the workers can go on. Among the pitiful sights of the world is that of men facing the serious business of the world's work undecided what to do, not having made up their mind, simply because they have no mind to make up, or because they have no point of contact with the world's practical interests.

One of the things, then, about which the world must be constantly busy is sorting out workers and giving them a chance. Milton tells a story very much to the point for our purpose: the evil spirit took the form of a toad, and thought that his true character would escape detection; but angel Ithuriel had a spear, to whose touch every object showed its true character. Laughing a divine laugh, Ithuriel touched the disguised spirit with his spear, whereupon the spirit was immediately transformed. Ithuriel knew all the while that it was no toad. Presently everybody else knew it as well. Experience plays the part of Ithuriel's spear. Experience reveals the worker, and it is the worker for whom the world is waiting. The rest must stand aside. The mother who had been successful in rearing seven splendid sons, asked how she had raised them, answered that she had raised them "by prayer and hickory." The providence that compels a man to work is at the last kind, just because it has been merciless, and close by diligence lies the reward of diligence. We can well afford to work hard five years, ten years, half a lifetime, if need be, for the sake of getting the ability to work harder. Keeping everlastingly at it brings success.

And yet mere plodding will not do. That is another of our pleasing fictions: that the man who works hard and forgets himself is bound to succeed. If that were so, some of us would simply startle the world with the wonderful things we should accomplish. Just because we are mere plodders we keep plodding, and get our reward—in the plodding. Luck has a mother's love for skill. A great deal of the time fortune passes by on the other side simply because she finds that a plodder is simply plodding. Skill is the faculty of adjustment, the ability to get hold where there is something to get hold of. Two tramps were held up by a dog. The man in the rear, of course, was the braver, because he was farther from the point of danger, and said to his companion, "Go ahead, he won't bite; don't you see he's wagging his tail?" The other man replied, "Yes, I see him wag his tail, and I hear him growl, too, and I don't know which end to believe." We need to know how to get hold of the manageable end of a problem. Skill is the faculty of adjustment, the ability to get hold of the manageable factor. Sometimes skill shows itself in a wise specialization. Wise men say the man of one idea may bear in mind that his idea is not the only one. A man gets the idea that his idea is the only one, and it narrows him to specialty, and he never gets his work jointed to the world. "The specialist who is only a specialist is no specialist at all," says the Rector of Heidelberg University.

It is one of the educational commonplaces of our day that American success in winning the right of way in the world's work is largely due to the general intelligence and general preparation of American manhood, superior general preparation making special adjustment easier. Wise specialization always presupposes a general background.

Of course, there are limitations, and it is useless to talk about skill as if it would do everything. At our best we have to acknowledge limitation. There are conditions that even the skill of the medical profession can do no more than call attention to. The demonstrator was speaking to his class in clinic, called out the brightest man in the class and said, "Mr. Smith, the affliction of this man leaves him with one leg shorter than the other, causing him to limp. Now what would you do in such a case?" "Why," he said, "I think I should limp, too." It is no use to set out without regard for our limitations. We are more and more compelled to face the fact that there are world elements human power cannot control. May 7th, St. Pierre was declared safe. Wise men had taken the readings off the lips of the crater and they spelled safety for St. Pierre, and St. Pierre settled itself in comparative safety. The eighth of May it was a city of death—in less than twenty-four hours a charnal house, a flood of melted rock carrying death wherever it went. The world is full of such elements, and there are conditions which not even your skill can alleviate. But none the less, perhaps all the more because these conditions exist, you must keep working continually. The world needs your skill. Always remember this. Every treatment of disease is the matching of intelligence and good will against malignancy. Remember that you control the real remedial agencies of the world. Remember that in your calling you are doing the work of the Great Healer after him. You are to use your skill not only to restore the sick to health, but to make well men to keep well. You are the Bishops of the public health. The plain every-day mercies of freedom from sickness are, after all, the finest tribute to the sleepless sentinels who guard the doors of life, both at its beginning and at its close.

Words count for little, but getting into the real sweep of things counts for everything. I speak of no narrow thing when I tell you that you will sooner or later have to face the problem of what your own life means. Faith is the very heart of life. What I have in mind you will find in the experience of the friend of whom Tennyson speaks :

"Perplex in faith, but pure in deeds,

At last he beat his music out.

There lives more faith in honest doubt,

Believe me, than in half the creeds.

He fought his doubts and gathered strength,

He would not make his judgment blind ;

He faced the spectres of the mind, and laid them.

Thus he came, at length,

To find a stronger faith his own,

And power was with him in the night

Which makes the darkness and the light,

And dwells not in the light alone,

But in the darkness and the cloud,

As over Sinai's peaks of old,

While Israel made their gods of old,

Altho' the trumpet blew so loud."

When you reach the hour of spiritual crisis will you recall the words of this

hour? I speak as a friend. There is no atheism on earth so awful as the lack of an ultimate ideal, and faith is the recognition of an ideal. The life is lost that is not shaped up to a worthy ideal. The ideal may not mean money, it may not mean material good at all, but it does mean life.

Novalis has worthy word: "Philosophy can bake no bread, but she can give to the soul God, freedom and immortality." Miss Freeman, now Mrs. Palmer, while President of Wellesley College, said to the students there, "Girls, let me tell you this: a college education may not add a single loaf to your larder, but, believe me, it will make every morsel that does come to you taste sweeter." We talk about utility. When we come to consider utility we ought to consider the fine thought of Socrates, who defines utility as "that which conforms to the dignity of manhood and to true liberty." This is the injunction I lay upon you in this hour, to see that you are cherishing a worthy conception of life. In measuring opportunity and duty, you will do well to think not so much of something to get, but as of something to give. The natural and the wise course is to use one's powers for the good of others. The flower that refuses to breathe out sweetness withers. The water that refuses to flow stagnates. The life that loses itself within itself perishes. I do not know why I am telling you this little story, for very likely it was known to you before it was to me; but it illustrates so admirably the thought that visits us just now, that I am going to repeat it. It was a physician's son who sat on the doorstep of his home, when a stranger approached, inquiring for the physician. "My boy, is your father at home?" "No, sir," said the boy. "Can you tell me where he is?" The little fellow replied, "I can't tell you exactly where he is, but if you want to find my father you will have to go where somebody is sick, or hurt, or something like that, because he is always helping somewhere." Never take the mean view of your power. This thing happened in Philadelphia: Two physicians were in consultation over a man who was suffering intense pain. Money was no object with him, for he had abundant means. The physicians were in a room apart, debating the likelihood of the man's suffering continuing for a considerable time. They did not know that a partly opened door allowed their voices to carry to the family, but such was the fact, and part of the conversation that was carried ended with a heartless laugh, as one of the physicians said to his professional brother, "Well, this means so much more bread and butter for us." Unprofessional, you say. Yes, and more than that—inhuman.

The most stalwart of England's living poets has given the world a message concerning "The White Man's Burden." "The White Man's Burden" is real. Since the beginning of the world the higher has been compelled to bear the burden of the lower. This is the law of the universe, from which even the Almighty is not exempt. The "White Man's Burden" is real, but back of the white man's burden is the white man's strength. In this is a rough parable for you. Your personal responsibility is very great. Matching the demands upon you is your fitness to serve. There is always strength in high purpose. We may conceive of our calling, your calling and mine, as the opportunity which God has given us for the uplifting of the world. With that conception, a man goes to his work with the feeling of competent authority, and in that thought is strong. The Massachusetts constable, who stood about five feet six inches in height, had the idea. He was sent to arrest a great, burly culprit. The big man threatened the constable, saying, "If you come near me, I will shake you out of your boots." The constable replied, "You can shake me if you want to, but remember, you are not shaking a little chap of five feet six, but you have got to shake the whole State of Massachusetts." A man may go safely if his purpose is high. This world is an honest world,

built by an honest God for honest people. The man who moves out to his work, doing the best that is in him, will find that the whole universe is at his back.

Gentlemen, the world is forever calling for brave, clean, strong men. As such you go to meet the world's need. God speed you.

The degrees were conferred upon the following sixty-eight graduates by Judge Hanna, who is President of the College.

Julian Adair, Wilmington, Del. ; William Knight Adams, Philadelphia, Pa. ; Franklin Endress Bamberger, Lebanon, Pa. ; Harold Lee Barnum, Philadelphia, Pa. ; George Fravel Barry, Chicago, Ill. ; James Russell Bibighaus, Philadelphia, Pa. ; C. Albert Bigler, Philadelphia, Pa. ; Raymond A. Bissey, Philadelphia, Pa. ; Emanuel Stratton Black, Swedesboro, N. J. ; Frank Halstead Brown, New York, N. Y. ; William Hayes Brown, Frederick, Md. ; William Ralph Buchanan, Palmyra, N. J. ; Horace Greeley Carmalt, Indiana, Pa. ; Wm. Paxson Chalfant, Stroudsburg, Pa. ; Allison Holstein Coulston, Philadelphia, Pa. ; Ralph Deming, M.E., Philadelphia, Pa. ; T. Snively Dunning, Philadelphia, Pa. ; Norman Felton Edwards, Welch, W. Va. ; David Wenger Ensminger, Philadelphia, Pa. ; George Robinson Foulk, Wilmington, Del. ; Albert Rowland Garner, B.S., Philadelphia, Pa. ; James Monroe Goodman, Cumberland, Md. ; Charles Pickhardt Haller, Yalesville, Conn. ; John Marvin Hanna, West Chester, Pa. ; Edward Harris, Jr., Moorestown, N. J. ; Malcolm David Holben, Slatington, Pa. ; John Huey Humes, Hollidaysburg, Pa. ; Arthur J. Huselton, Delaware, N. J. ; Frederick Charles Hutton, Philadelphia, Pa. ; Earle Hoopes Ingram, Philadelphia, Pa. ; Walter Reed Iszard, Woodbury, N. J. ; John Edwin James, Jr., B.S., Philadelphia, Pa. ; Frank Lehman, Chambersburg, Pa. ; James Clarke Logan, A.B., Allegheny, Pa. ; Arthur Lee MacKenzie, Philadelphia, Pa. ; Elmer Harold Maurer, M.E., Ashland, Pa. ; George Booth Mitchell, Kane, Pa. ; George W. Mitchell, Philadelphia, Pa. ; Alfred Milton Moore, Denver, Col. ; Isaac E. Morris, Alliance, O. ; Claude Alvoi Morrison, West Point, Va. ; Amar Nath Mukerjee, Calcutta, India ; Maurice Henry Neumüller, Lansford, Pa. ; Frank Edwin Nichols, Greenville, S. C. ; Wayland Ray Palmer, McEwensville, Pa. ; Harry Rile Pennock, Wilmington, Del. ; Henry Evans Porter, Philadelphia, Pa. ; James Howland Prior, Vineyard Haven, Mass. ; George Earle Raiguel, Philadelphia, Pa. ; Harry Harbaugh Rhodes, Saxton, Pa. ; Elisha Roberts Richie, B.S., Moorestown, N. J. ; Walter Bright Rile, B.A., Philadelphia, Pa. ; Robert Montfort Schley, Philadelphia, Pa. ; James Dobson Schofield, Philadelphia, Pa. ; George C. E. Simmer, A.B., Philadelphia, Pa. ; Thomas Waterhouse Skirving, B.S., Philadelphia, Pa. ; John Elmer Snodgrass, Jamestown, Pa. ; Charles W. A. Stegmenn, Philadelphia, Pa. ; Otis D. Stiekney, Atlantic City, N. J. ; Geo. Asher Strader, Philadelphia, Pa. ; John Chalmers Sutton, Butler, Pa. ; Robert Stafford Tyson, A.B., Frederick, Md. ; Samuel Burns Van Dalsem, Frederick, Kan. ; Sam Bell Wakefield, San Francisco, Cal. ; George Harlan Wells, A.B., Elkton, Md. ; Arthur Bent Williams, Iona, Minn. ; William Rendell Williams, Philadelphia, Pa. ; Charles Aaron Wright, Delavan, Wis.

Alumni Association of the Hahnemann Medical College.—Meeting held in Hahnemann Medical College, Thursday afternoon, Philadelphia, May 15, 1902. A committee was appointed to nominate officers for the ensuing year. The Necrologist's report was then read by Dr. Willard, of Reading, Pa. There being no objections, the report was accepted and filed. The Treasurer's report was next read by the Secretary ; and, there being no objections, it was accepted and filed. New business being then in order, the following committee was appointed to offer suitable resolutions regarding Dr.

Helmuth's death : Dr. Dudley ('61) ; Dr. J. C. Guernsey ('72) ; Dr. Bushrod W. James ('57). Dr. John R. Fleming ('82) was appointed Necrologist for the ensuing year. The Association then listened to the report of the Dean of the Faculty, Dr. Pemberton Dudley, who said :

The colleges of the eastern shores, here—Boston, New York, Philadelphia, and Baltimore—are sending out less than two hundred physicians per annum. Now, gentlemen, think of it ! The western schools, combined, are graduating, in proportion to the number of physicians in that territory, two graduates to our one in the east. We are not sending out as many students as is necessary to provide for the increase in population and to recoup the death losses. In other words, in proportion to the population in this country, homœopathy numerically is not growing !

PRESIDENT : I would like to supplement Dr. Dudley's remarks by saying that the same condition obtains in the west. We have any quantity of small cities in Wisconsin, Minnesota, North and South Dakota, with from 2000 to 800 inhabitants, where there are no homœopathic physicians. I have from 10 to 20 applicants every year from good-sized places for a homœopathic physician. Something ought to be done. Something ought to be done in a missionary work throughout this country to encourage young men to settle in the country and in the small places, rather than in the large places.

Officers elected for ensuing year : *President*, Dr. D. P. Maddux, Chester, Pa. *1st Vice-President*, Dr. C. H. Goodman, Dr. Price, Baltimore ; Dr. A. C. Heritage, Jenkintown. *Treasurer*, Dr. Keim, Philadelphia. *Permanent Secretary*, Dr. Woodward W. Carter, Philadelphia. *Provisional Secretary*, Dr. D. B. James, Philadelphia. Unexpired term, Dr. D. J. Burlinghoff, Scranton ; *Executive Committee* for the following three years : Drs. Leopold, Swartz and Hassler.

Few remarks made by the newly-elected President.

Mr. President and Gentlemen : This great honor coming so unexpectedly, I feel entirely unable to explain it or properly respond to it. Coming, as this position has already, to distinguished leaders in the profession, I can only feel that some of my friends must have thought that it was time to honor the rank and file. As such an honor I very highly appreciate it, and it will be my pleasure to advance the interests of the Alumni and Old Hahnemann.

(There being no more business before the Alumni, the meeting adjourned at 5.38 P.M.)

Hahnemann Alumni Banquet, Horticultural Hall, Philadelphia, May 15, 1902.—At 10.12 P.M. the Faculty and Officers of the Hahnemann Medical College marched into the banquet hall, followed by the members of the Class of '02. Earlier than the time specified for speech-making, Dr. John E. James, owing to recent illness and desire to arrive home soon, delivered his address on "The Faculty."

Toastmaster (Dr. H. L. Northrop) : In view of the recent illness of one of our speakers who desires to retire early, the chair will now call on the response to the toast, "The Faculty."

DR. JOHN E. JAMES : *Mr. Toastmaster*—You have made reference to the recent unpleasantness that I had with two or three physicians of Philadelphia that lasted for two or three weeks. They were the stubbornest set of doctors I think I ever met. They refused to receive any advice whatever from me (laughter), and there was never a request I made but what they refused except that I should be excused from coming to this place to-night, and they readily agreed to it. But the other night they came to me and told me that they had reconsidered it, and that it was necessary for me to come.

I want to say to you young men, who have just come into the profession, that we extend to you a very hearty and cordial welcome, not only to this banqueting feast, but to the profession. We recognize you as peers—you are no longer students of old Hahnemann, but students in the peerage of the profession! Only a little while ago you received your parchment which tells you that you are prepared now to go before any State Board and get—try to get—(laughter) a license for the practice we have been teaching you for the last four years. (Applause). (Interrupted by refrain from “Auld Lang Syne” from Class of ’02). No, I say you are not students of Hahnemann, but you are rather students of humanity. You are students of that great art that is for the relieving of the ills of the flesh, prolonging and saving of human of human life. Your colleagues that you see around you have done noble work in the profession—both the names among the dead and among the living. They have carried the pinnacle of honor and fame of your profession to lofty peaks, and we believe that we have a right to expect of you young men, with your broader education, with your more complete furnishings, even greater things. I bid you go on; and in your work that you begin to-night, nurse your zeal, nurse your enthusiasm, and work and work and work until you have placed the banner of that profession on still higher peaks, and may God speed you to ultimate success. (Applause and college yell).

(After Dr. James’ speech the feasting was resumed until about 12.30, when the speech-making was begun, as follows:)

Toastmaster: Gentlemen, you have undoubtedly noticed how very quiet those sitting at this end of the table have been to-night. I have watched these alumni closely, and while they have said little, they have been thinking a great deal. And it now becomes the pleasant duty of the chair to ask several of these gentlemen (provided they are not suffering from impedimenta from too much dinner) to tell us what they have been thinking about.

And we welcome the Crown Prince Alonzo because he is heir to the throne of affection and respect in our hearts; because he is the first choice of the Hahnemann Alumni Association for its executive officer; because he has won the respect and affection of all with whom he has come in contact during his twenty-six years of medical life. These are a few of the reasons that give the chair great pleasure in calling upon Alonzo P. Williamson to respond to the toast, “The Loyal Alumnus.” (Applause and college yell.) (Address, “The Alumni,” by Alonzo P. Williamson, read.) (Following the address, Sir Arthur Jackson sang a solo.)

Toastmaster: I think you will all agree with the chair in entertaining a very high opinion of William’s-son. His words should sink deeply into the heart and sober thought of every alumnus of old Hahnemann. It is not the expression only, but it is also the thought, the spirit back of it, that gives weight and lends importance to the utterance.

The Frenchman who is here to-night is a New Yorker (although it is within his power to correct it), and he is going to give us a tip on how a physician may achieve success in politics. The leading part in “York State Folks” will now be played by Dr. John W. Le Seur, of Batavia, N. Y.

DR. JOHN W. LE SEUR: Your Toastmaster said that the gentlemen sitting at this table would give expression to some of the thoughts that had been running in their minds while sitting here, and he spoke better and more truthfully than he knew, for some of the thoughts that have been running in my mind will have expression now; but they were not the thoughts that were dwelling in my mind in anticipation of this event.

You, young men, have advantages that we did not have; and I say this, recognizing the fact that some of the teachers who taught us have taught you.

But I want you to remember this—remember it as a truth stated regarding your faculty, and no one honors them more highly than your speaker—remember this, that every teacher, if he is faithful in the performance of his duty, gains power to teach, gains a peculiar ability, a peculiar facility in the imparting of instruction; and you who sit at the feet of the older teachers to-day have the advantage of that experience and wisdom that comes of practice and study. The element of kind must enter into every theory of education. You are taught by the older instruction, by better teachers than we were. Better than that, you have had the advantage of instruction by some men who have grown up and grown into the teaching faculty since we went out. Ours was the last class out of the old College, and we carried, as mementos, rods from the old stairway; some of us have canes at home made of these old baluster-sticks. You have, I say, the advantage of teaching by men who have come into the faculty since that time, and have grown up. Still, you do not recognize it now, as you will when you come out into the broader field, see more men and measure all men, as you have in Philadelphia, as teachers in this College Faculty—men who are peers of any teachers on God's green earth to-day. (Applause.) Does it count for nothing that men go out from the College of Philadelphia and take positions in New York, in Chicago, in Rochester and Buffalo, after taking a competitive examination for these positions, and recognizing the fact that in these cities are colleges that hold up their heads and think that they are as high as any intellectual and scholastic attainment, as any colleges? And when compared by this institution, your men and our men, going on to the prosecution of life's work, take hold of life's position and follow that grasp, whereas some of those graduating at other places are like shingle-nails. (Applause.)

I was glad and proud when the Secretary of this Association said to me, by letter, "Come home and speak to the boys!" I am proud of Hahnemann College. I am proud of the loyalty of her sons, I am proud of the achievements of her sons, I am proud of the scholastic attainment of her sons, I am proud of the ambition of her sons. I am proud, as I said, of the loyalty of her sons. But there is one thing I believe Hahnemann College needs; that is, for want of a better name, I will call it *esprit de corps*—a kind of loyalty, a fellow-love for one another—a kind of feeling that makes every one reach out and take each other by the hand; and wherever we hear of an alumnus of old Hahnemann in a helpless condition, and we can lend him support, we will go out of our way and be glad to do it. That is the spirit of love one for another. That makes me more proud of old Hahnemann than any other college I know. (Applause.)

With the pleasantries of this reunion one thought grieves us to-night. One of the most loyal, one of the most kindly, one of the intellectual giants, one of the fearless defenders, one of the noblemen in the practice of homœopathy has recently fallen. He was our friend and our brother; he was a member of this Alumni Association, and we have never listened to words more stirring, never to sentences more sympathetic and polished, never to words more poetic and thrilling, than those rendered to us and for us by our late beloved and lamented Dr. William Tod Helmuth. Peace to his ashes!

Dr. Julian Adair then spoke on behalf of the Class of 1902, scoring the faculty and students in a pleasant way.

Pulte Medical College Commencement.—The 30th annual commencement of Pulte Medical College was held on Tuesday evening, May 6th, at 8 o'clock, in the Scottish Rite Cathedral, Cincinnati, Ohio.

The New York Homœopathic Medical College and Hospital Commencement.—The 42d annual commencement of the New York Homœopathic Medical College and Hospital was held on Thursday, May 8th, at 3 o'clock, Mendelssohn Hall. Twenty-three graduates.

For Sale.—A physician's house and business location. Owner desires to retire. A large practice, established twenty-five years, in a large New Jersey town, near Philadelphia, with twenty growing surrounding towns. Attractive house of twelve rooms in best location, with large grounds, fruit, flowers and shade. Applicant must have cash for part payment. No better opportunity could be offered. Apply "A. B. C.," care THE HAHNEMANNIAN MONTHLY, 1506 Arch Street, Philadelphia.

The Minneapolis Homœopathic Medical Society.—The Minneapolis Homœopathic Medical Society has just been successfully reorganized with a membership of fifty, which includes practically all of the homœopathic practitioners of the city. Its purpose is to secure united action in all matters affecting its members and to strengthen homœopathy in the community. One of the specific pieces of work likely to be undertaken by the society is a renewal of efforts to secure a separate medical college at the State University. The meetings of the society are to be held the second Wednesday of each month at the homes of the members. The April meeting will be held at the home of Dr. Adele S. Hutchinson. The officers of the society are: *President*, Dr. H. C. Aldrich; *Vice-President*, Dr. Adele S. Hutchinson; *Secretary*, Dr. O. K. Richardson.

The Institute Committee on Revision of the By-Laws have, as per instructions, prepared a schedule which will be found in the Secretary's annual circular.

As space there would not permit of a thorough explanation of the plan proposed, we desire to present the same to the profession through the journals, that all members may study and understand the plan before the meeting.

1. The schedule has been arranged so that all meetings may be held within the week.

2. It has provided seven hours for the general business of the Institute—ample time.

3. It has provided one whole day, six and one-half hours, for the sole consideration of materia medica—the keystone of our faith, and without it we have no reason for our distinctive organization.

4. It recognizes the fact that the majority of our members are general practitioners, and that their rights must be protected. We have therefore provided for them six and one-half hours of materia medica and one and a half hours upon each department of medicine, and in which practical rather than technical papers should be presented. They also have the right and privilege of attending any or all of the special societies they desire.

The committee believe that any schedule providing for special societies alone should not prevail, because it takes from the general practitioner and adds to the specialists the benefits of membership. The Institute cannot publish in any way the transactions of all the special societies and their own without increasing its dues. This makes the general practitioner pay more than at present and the specialist less, as it cuts off the dues of his special society. Under the proposed schedule the Institute would publish its general business, statistics, etc., all the materia medica meetings, and the general scientific meetings, held daily from 10.30 to 1.30; so that the Institute members would receive, in return for their dues, a volume of *Transactions* of about the same size as at present, while the special societies would be allowed to publish their own transactions.

5. This schedule gives the special societies what they want, ample time to hold their meetings during the week of the Institute, and we believe will be entirely satisfactory to them.

Lastly: It does not saddle the expense of the special societies upon the Institute, which it cannot stand without increasing its dues, and we believe any increase of dues would greatly cut down our membership, and in that way injure the life of the Institute.

Theo. Y. Kinne,
Chairman.

American Institute of Homœopathy.

OFFICE OF THE PRESIDENT.

CLEVELAND, O., May 20, 1902.

To the Members of the American Institute of Homœopathy: All arrangements for the Fifty-Eighth Annual Meeting of our National organization, to be held in this city, June 17th to 21st, are now complete. Present indications fully justify the assurance that, in the matter of attendance, in its interest, and in its special features, it will greatly excel any previous meeting in the history of the Institute.

Cleveland is a summer city. In our week in June it will be at its best. It promises cool nights and pleasant days, while its shaded streets, its beautiful Park system—which is Cleveland's especial pride—and its water-front, all combine to make it attractive to the visitor and refreshing to those who will next month enjoy its hospitality.

The spontaneous response that the special feature—the College Alumni Conclave—has brought forth, of itself guarantees a large attendance and an intense interest. It is thought that this occasion will do much to create increased interest on the part of each Alumnus in his own Alma Mater.

Members of the profession should realize that the present is a critical period in our history. Events of great importance are at hand. In the law-making bodies of many States radical legislation is about to be attempted vitally affecting our interests as a school. The Institute is the most powerful guardian of your rights. Never before was a strong organization so important. Each one must do his part. Come and lend your aid.

The various social functions that have been provided by the local profession, while adding much to the enjoyment of the visiting members, will in no wise interfere with the serious work of the Institute. They are all planned to take place outside of the hours devoted to the business and scientific sessions. They will consist of the Conclave, a reception and dance, of drives and trolley-rides, while there will be rare opportunity to indulge in golf and wheeling.

The Chamber of Commerce Building, in which the sessions will be held, is unusually well adapted to our purposes. The Hollenden Hotel, which will be Institute Headquarters, is a first class house, and the entertainment will be of the best. But, in addition to this, there are many other hotels, of all grades and prices. Cleveland is very easy of access from all parts of the country, and the Committee on Transportation has arranged for a fare of one and one-third for the round-trip from all railroad centres east of the Rocky Mountains.

On the part of the profession and the citizens of Cleveland a hearty welcome awaits all who may come.

Ch. Gatchell, M.D.,

Secretary.

James C. Wood, M.D.,

President.

The Raue Medical Club held their 16th regular monthly meeting on Tuesday, May 6, 1902, at the home of Dr. A. L. Baker, 1400 Twelfth Avenue, Altoona, Pa. The meeting was called to order at 3.30 P.M., and the regular business gone through, after which a paper on "Cystitis" was read by Dr. Baker, which was followed by a general discussion.

The following members were present: Drs. Morrow, Sharbaugh, Baker, Peiper, Wesner, Stitzel, Taylor, Blackburn, Bohn, Hoy and Humes.

Daniel Bohn, M.D.,

Secretary.

Hospital Appointments.—*Hahnemann Hospital of Philadelphia*: Drs. Horace G. Carmalt, John E. James, Jr., Frank Lehman, Harry R. Pennock, G. Harlan Wells, Wm. R. Williams. Alternate, Dr. C. Albert Bigler.

St. Luke's Hospital of Philadelphia: Drs. Julian Adair, Walter B. Rile.

Children's Homœopathic Hospital of Philadelphia: Drs. Franklin E. Bamberger, Amar Nath Mukerjee.

Scranton, Pa., Homœopathic Hospital: Dr. Malcolm D. Holben.

Homœopathic Hospital of Pittsburg, Pa.: Drs. James C. Logan, John C. Sutton.

National Homœopathic Hospital, Washington, D. C.: Dr. Wm. R. Buchanan.

Homœopathic Hospital of Buffalo, N. Y.: Drs. Charles P. Haller, Thomas W. Skirving.

General Homœopathic Hospital of Rochester, N. Y.: Drs. Robert Montfort Schley, John E. Snodgrass.

Grace Hospital of New Haven, Conn.: Dr. Albert R. Garner.

Metropolitan Hospital of New York City: Drs. Frank H. Brown, John M. Hanna, Maurice H. Neumiller, Geo. A. Strader, James D. Schofield, Sam Bell Wakefield.

Brooklyn Homœopathic Hospital: Drs. Walter R. Iszard, Elisha R. Richie.

Albany, N. Y., City Homœopathic Hospital: Drs. W. Hayes Brown.

The Atlantic City Homœopathic Medical Club held its monthly meeting at the Hotel Strand, April 18, 1902, as the guests of Drs. Crosby and Lyon.

President Dr. William G. Gardiner in the chair, and the following members present: Drs. Baily, Balliett, Bewley, Crosby, Fleming, Gardiner, Hood, Hughes, Jackson, Lyon, Munson, Sooy and Westney.

After the routine business, Dr. John R. Fleming read the paper of the evening—subject, "Echinacea Angustifolia." The discussion brought out the fact that the members had received much benefit by its use.

At eleven o'clock the members of the Club, with their ladies (who joined them at this time, after holding their own meeting), and their guests, Dr. and Mrs. Walter Scott McFayden, of Manayunk, Pa., were entertained in the hotel dining-room.

The monthly meetings are well attended, and keep the Club actively at work in research work.

M. S. Lyon, M.D.,
Secretary.

The Chicago Homœopathic Medical College.—The following-named members of the Faculty have resigned their positions in that institution: Dr. Chas. Gatchell, Dr. Chas. Adams, Dr. W. S. White, Dr. A. E. Thomas, Dr. W. S. Thomas, and Dr. C. A. Weinick.

The Raue Medical Club.—The "Raue Medical Club" of Central Pennsylvania held its fifteenth regular meeting at the home of Dr. M. A. Wesner, Johnstown, Pa.

The following members were present: Drs. Wesner, MacDonald, and Sanderson, of Johnstown; Drs. Morrow, Sharbaugh, Baker, Stitzel, Bohn, Hoy, Blackburn, and Taylor, of Altoona; Drs. Stitzel and Humes, of Hollidaysburg; Dr. Peiper, of Tyrone; and Dr. Davies, of Windber.

Dr. Wesner read an excellent paper on gall-stones, and cited a number of cases from his practice. A general discussion followed the reading of the paper, after which a lunch was partaken of.

The meeting adjourned to meet next month at the home of Dr. Baker, of Altoona, Pa.

Daniel Bohn, M.D.,
Secretary.

THE HAHNEMANNIAN MONTHLY.

JULY, 1902.

DIET IN ARTHRITIC DISEASES.

BY WILLIAM H. VAN DEN BURG, M.D., NEW YORK.

(Read before the Homœopathic Medical Society of the State of Massachusetts, April 8, 1902.)

THE subject of diet in arthritic diseases is for the practitioner a most discouraging one, owing to the widely diverging views held by the various authorities upon the subject. These conflicting opinions are largely the result of imperfect knowledge of the etiological factors in the various diseases producing inflammation of the joints. My belief is that these views will not be brought into complete unison until a more perfect knowledge of the chemistry of tissue metabolism and of the action of bacterial toxins upon different tissues is at hand.

The trend of modern research has been toward identifying micro-organisms as causative factors in different diseased conditions. Comparatively little is known of the chemical results of the growth of these various bacteria in the tissues of the human body. Even less is known at the present time of the effect of different food principles upon the chemical composition of cellular elements.

It seems to me that we have now nearly reached the limit in microscopical research, and that our future knowledge is to be enriched principally through the study of the chemistry of tissues as influenced by food and by disease. Until this knowledge be forthcoming, the curative or preventive use of food in all diseases must be almost purely empirical.

In most arthritic diseases the real cause of the effects upon the joints is but little understood. While we know that in many cases the joint-inflammation is due to the fact that the system has been invaded by some one or other organism, we also know that these same organisms frequently are present in the human body without producing any direct effect upon the joints themselves. Why it is that in one case the joints are affected and in another they go free is, as yet, the unsolved problem of chemistry.

With this preliminary excuse for the failure to present to you more positive conclusions, we will proceed to a more definite consideration of diet.

For the purposes of dietetic treatment, arthritic diseases fall into three, or possibly four, classes, viz.:

1. Toxic arthritis.
2. Rheumatism, acute and chronic—these two classes probably being only different manifestations of toxic arthritis.
3. Rheumatoid arthritis.
4. Gout, including lithæmia.

The first division, toxic arthritis, the result of gonorrhœal or streptococcic infection, can be disposed of in a few words so far as the diet is concerned. These particular infections attack the joints only in such cases as are poorly nourished, or have what is usually called a low nerve-tone, these expressions being used simply to denote lack of immunity of the parts to the particular infection. Therefore, the indications for diet are those of acute infectious or febrile diseases generally. Of the reasons for this diet, more later. I would simply say, here, that in septic arthritis alcohol seems to be very well tolerated, and tends to prevent, to a certain extent, nitrogenous waste.

Acute Rheumatism.—In the last few years clinicians have been more and more of the opinion that here, too, we are dealing with some infectious micro-organism, and much has been done during the past year to confirm this belief. Yet how are we to prescribe a successful diet in this condition when authorities differ so widely about its cause? For instance, Bosanquet, in a recent study of 450 cases, says, that “the large proportion of domestic servants affected is probably due to the fact of their liability to be poorly nourished, and to suffer from anæmia, and thus present a low resistance to the microbe of rheumatism;”

while another (Porter) says that "the complex chemico-suboxidation problem, with its associated toxic condition of the system, which has for so many years been included under the so-called rheumatic condition, can be looked upon as the direct etiologic factor in producing the lesion and symptoms of so-called acute articular rheumatism in all its varied forms."

It is hard to reconcile these views, yet the weight of evidence appears to me favorable to the infection theory; and dealing practically with rheumatic fever on that basis seems to give the best results.

For purposes of diet, this brings me back to an acute, febrile, infectious disease, where we have an increased destruction of nitrogen-containing tissues. In this acute febrile condition it has been found practically impossible to bring about a nitrogenous equilibrium by feeding food containing large quantities of nitrogen. Besides, much nitrogenous food tends to flood the circulation with the products of nitrogenous waste, already too abundantly present, thus tending to increase the strain upon the kidneys and increase the tendency to toxæmia, which is also already markedly present.

To quote from Hutchinson, "It, therefore, seems best to give a diet rich in proteid-sparers rather than proteids themselves," such as gelatine, carbohydrates and fats. For various reasons, of these the carbohydrates are practically the only ones available for fortifying this diet. The combination of food-principles represented by milk is usually the most acceptable as a basis for diet in acute rheumatism, as well as in other febrile conditions. Two quarts is about the proper quantity to be given to an adult each twenty-four hours. The milk may be flavored with coffee or malt extract, or other flavoring substance, if this adds to its acceptability to the patient. If not well digested it should be peptonized, or koumiss or matzoon substituted.

With the idea of supplying more carbohydrate, one or two teaspoonfuls of milk-sugar may be added to each tumblerful of milk, or; even better, alternate milk with cereal preparations, as oatmeal, arrowroot, various prepared foods, or malted milk. The milk may also be fortified by the use of plasmon, somatose, or cream, if less than three pints are taken in a day.

Where very little food can be taken, egg whites are useful,

or broths may be alternated with milk food, though it seems best to avoid broths in this condition wherever possible. White of eggs with twice the quantity of water, strained, and a teaspoonful of beef-extract added, makes a palatable and nutritious as well as cheap food. Burney-Yeo recommends a nutritious beverage, made by mixing a pint of milk, a pint of boiled water, eight to twelve teaspoonfuls of sodium bicarbonate, and two to five of common salt—the whole to be cooled, and a glassful administered every two hours. The milk may also be given diluted with carbonated water.

There has recently been a tendency to allow a more generous diet in all febrile conditions, and in asthenic cases of rheumatism it is well to give as much of the above food as can be digested.

To supply the waste from excessive perspiration, it is *always* necessary to give large quantities of pure water. In *subacute* rheumatism, or in cases convalescing from an acute attack, the albuminous foods which seem best adapted are eggs, fish, oysters, sweetbreads, and the white meat of chicken. Green vegetables are usually well borne, such as peas, string beans, spinach, boiled celery, asparagus and lettuce. A baked or mashed potato can usually be added with advantage. Oranges and baked apples are the best of the fruits. Very acid fruits or sweetened preserves should be avoided. Tea, coffee and cocoa it is usually best to exclude until convalescence is well established.

Many of the so-called *chronic rheumatic states* are due to auto-infections or to the absorption of the imperfectly digested foods or waste products from the intestines. In other words, the suboxidation of Porter here plays an important part. Others are very nearly allied to the so-called gouty condition, which is also most probably a condition of suboxidation. Others, again, are a beginning cirrhosis of the kidneys, etc.

From this it will readily be seen that any hard and fast dietetic rules cannot hold good. One case may need an increase of proteid, while another does best on little or no proteid, while more will do better by restricting the total amount of food taken rather than any particular kind.

This is illustrated by a recent case: A working woman complained of constant and annoying pains in the joints and mus-

cles, so severe as to materially interfere with her duties as forewoman in a factory. She had also recently increased quite materially in weight. By decreasing her carbohydrates, leaving proteids unchanged, and giving more water, the weight has been decreased and the pains have disappeared. In many cases it is a question of oxygen and exercise rather than food; or, rather, the amount and quality of the food must be adjusted to the exercise taken and oxygen consumed.

Rheumatoid arthritis resembles very closely many chronic cases of rheumatism, yet the etiology of the disease is quite distinct. It is the consensus of opinion that the patient suffering from rheumatoid arthritis should be fed as generously as possible on a simple diet of mixed foods. Farinaceous articles, fats and oils are to be particularly recommended. In this disease, as in rheumatism, pure water should be freely given.

In gout, goutiness, and lithæmia, as in other articular diseases, chemical pathology has not furnished us with any very clear indications as to the best diet. The relations of uric acid and other catabolic products to general metabolism are still much in the dark. It is becoming more and more evident, from recent experiments, that uric acid is derived mainly from the decomposition of nucleins from the food or from the disintegration of body-cells, the latter being a quite constant amount, while the former varies with the amount of nuclein contained in food consumed. If this view be correct, we have a clear indication to avoid all foods rich in nuclein in gout or lithæmia.

These foods are:

1. Cellular gland organisms, such as thymus, liver and spleen.
2. All ordinary meats.
3. Meat extracts, tea, coffee and cocoa.

Milk, most vegetables, cereals, eggs and cheese yield little nuclein, and should, therefore, compose the diet in these cases.

Hutchinson says that "it is not the amount of proteid in the food which is of importance, nor is there any reason to believe that animal proteid, as such, is capable of yielding uric acid any more than vegetable. It is the nucleins that matter, and these happen to be abundant in animal foods only, though even amongst these, milk and eggs are free from them."

To my mind, however, this does not entirely settle the question of diet in the gouty and lithæmic. Experience teaches that quite as much attention must be given to the quantity of food as to the quality. It seems best that the gouty inclined should take comparatively little food, and that the animal portion of this food should be made up, as Hutchinson suggests, of milk, eggs, the lighter meats, and cheese. I think I have seen repeatedly, in this class of cases, benefit follow restriction in the use of red meats, especially beef and mutton. I find it quite the custom for people suffering from lithæmia and gout to take beef or mutton at one or two meals each day; and in many instances, in the winter season, oysters are also partaken of at one or more of these meals.

It is my practice to restrict the use of beef and mutton to once a week, the use of meats of any kind to not more than two meals in the day,—and here the quantity is also limited,—and I have yet to see a case that has not improved upon this regimen. I also believe it to be quite as important what the individual drinks as what he eats.

It is a generally accepted fact, in which I fully concur, that alcohol in every form is harmful to the patient whose system is given to the over-production of uric acid.

Sir Alfred Garrod expresses himself very strongly upon this point when he says: "There is no truth in medicine better established than the fact that the use of fermented liquors is the most powerful of all the predisposing causes of gout—nay, so powerful that it may be a question whether gout would ever have been known to mankind had such beverages not been indulged in."

Sir William Roberts states that "Alcoholic liquors are not all equally potent in fostering gout, and that this difference is not entirely due to their percentage of alcohol. Port, Sherry, Madeira, Burgundy, strong ales, stout and porter are much more powerful factors in producing gout than are distilled spirits.

"In Scotland and Ireland, where whiskey is in common use, gout is not nearly so prevalent as in England, where malt liquors are the popular beverages. In France, gout is most common in the Burgundy district, while in the sections of Germany where the various classes of Hock are consumed, gout is but little known.

“Champagnes are, undoubtedly, gouty wines, while cider has not much power in that direction. Gout is but rarely found among drunkards, but is rather an incident of the legitimate use of alcoholic beverages, taken in moderate quantities and with the food.”

The American habit of taking a cocktail before meals I believe to be a prominent factor in producing many cases of so-called rheumatism, but which are really examples of irregular gout.

Pure water, with as little solid matter as possible, and water that is especially free from lime salts, is about the only drink that can be said to be good for this class of people.

Sir William Roberts also contends that common salt is deleterious in the diet of the gouty; that it tends to promote the deposition of sodium biurate in the articulations. He says that this property is not possessed by the potassium salt, and therefore recommends and claims good results from the use of potassium chloride, in the place of common salt, in the preparation of food for those inclined to goutiness.

Further, I believe that children are fed too early in life upon meat juices, soups, etc. I have in the last year, in three instances, cured painful and persistent growing-pains in children of four to eight years of age by giving an almost exclusive milk and cereal diet. These children were pale, anæmic-looking, and for this purpose were being fed with beef two or three times a day. After the change the pains disappeared, and the ruddy color of health returned to the skin in the course of two or three weeks.

I have, upon several occasions, been called upon to examine the blood of apparently anæmic children, whose skin was white, mucous membranes pale, and for whom meat juices in large quantities, together with iron, had been prescribed for the anæmia.

In almost every instance the hæmoglobin would be found normal or above the normal, and the red cells would number over five millions to the cubic millimeter—showing, instead of an anæmia, a veritable plethora. By the substitution of a milk and cereal diet the blood became normal; and the appearance of anæmia, which appeared to be due to vaso-motor spasm, caused by the irritation of toxins derived from meat, entirely disappeared.

Therefore, to sum up the diet for the gouty and lithæmic, I would say that the food must be sufficient for proper nourishment only, the proteids be largely made up from the lighter meats, milk, eggs and cheese, *no* alcohol, and plenty of pure water.

COMPLETE LACERATION OF THE FEMALE URETHRA AND PERINÆUM.

BY THEODORE L. CHASE, M.D., PHILADELPHIA.

Gynæcologist to the West Park Hospital for Women.

LACERATION of the urethra following labor is of rare occurrence. When this does occur the lacerated area is usually small, and consists of an opening from the urethral canal into the vagina (urethro-vaginal fistula). The lesion is most often located at the vesicle end of the urethra, involving the neck of the bladder, and is associated with more or less injury to the base of the viscus proper.

These fistulæ, as commonly found in the anterior urethra, involve only the lower wall of the canal, extending from the urethral channel into the vagina; in other words, passing through half the tube.

The following rare and interesting case is described, as I have been unable to find its counterpart in the various treatises on gynæcology. I first saw the case on February 20th, and was given the history by the attending physician as follows: The patient was a primipara, aged thirty-five years, five feet seven inches in height, weight one hundred and thirty-five pounds, of strong, muscular form, and previously enjoyed good health.

The first stage of labor occupied fifteen hours; the second stage six hours, during which time forceps were applied. Severe traction was continued uninterruptedly throughout this stage. The third stage was completed in thirty minutes.

The first fortnight of the puerperium the patient's temperature ranged from 101.5° F. to 103.8° F. This was finally controlled by administering antistreptococcic serum, 30 c.c., repeated at eight- to twelve-hour intervals for three days.

The local examination revealed a lacerated urethra 1.5 centimeters from the external urinary meatus, and involving the

entire tube; so that the anterior portion extended forward and resembled a teat-like projection hanging from the centre of the vestibule (Fig. 1). The posterior part of the urethra was torn from its connective-tissue bed in the vaginal wall, and resembled a thin-walled muscular tube 2.5 centimeters in length, hanging downward into the vagina. Two tears were found on the upper vaginal surface, extending 6 centimeters on each side. Two acute-angled lacerations were noted on the posterior vaginal wall, extending upward and involving the lateral fornix on the right side, and the left extended to the cervix; both were to the rectal wall; so that the sense of touch with the examining finger in the rectum gave the impression of strong, cicatricial cords attached to the rectal walls.

The perinaeum was completely lacerated, as shown in the illustration (Fig. 1). The patient was admitted to the West Park Hospital for Women on March 31st, and operated on April 5th. The hanging urethra consisted of such thin tissues that denudation of this area was most tedious. After this was accomplished, the free ends were freshened, and, with the passage of a urethral catheter, sutures were placed longitudinally, so that the tying would bring end to end.

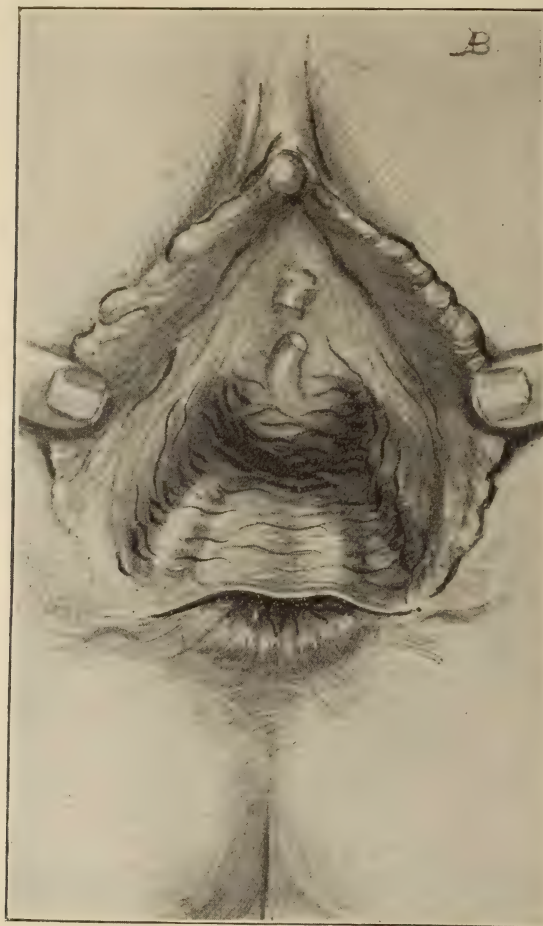
The denudation on each side of the urethra was carried a distance equal to one-third of its circumference, and sutures placed transversely, as shown in Fig. 2. The same is shown with the denuded areas brought together and the sutures tied (Fig. 3).

I have also shown (Fig. 2) a method of repair for complete laceration of the perinaeum used in this case. It consists of a combination of the methods used by several operators. I have found the results most satisfactory, leaving the patient with normal bowel function, a firm perinaeum, and the vagina so reduced in size and contour that its lower wall is retained in its normal position, extending well to the upper third.

A properly-restored perinaeum affords such marked relief to women, that time is well spent in giving a description of its successful performance. The technique of the operation has for its foundation the method of Emmet, and has been added to and improved upon, resulting in the present perfected technique. Dr. Charles Noble has placed great stress upon the particular direction in which the main sutures are placed, and

herein lies the important feature in the operation; for if these sutures, three on each side, and the following crown suture, extending through from side to side, are not put in as herein-

FIG. 1.

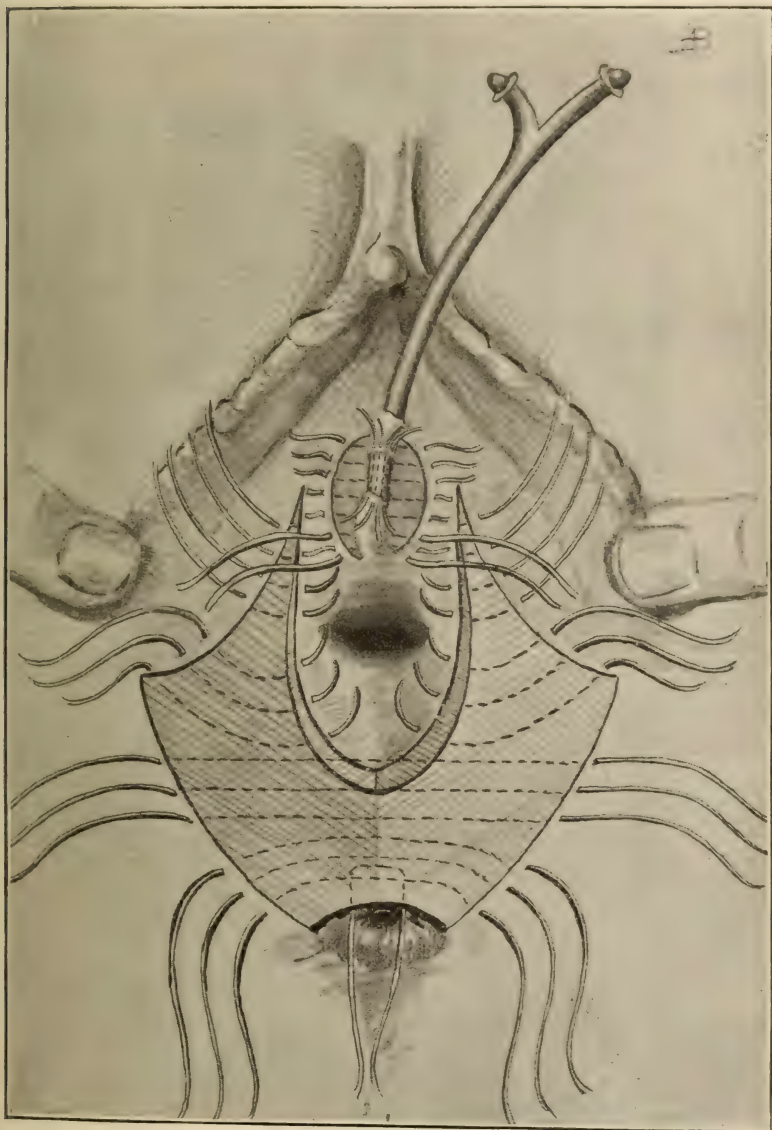


Showing a teat-like projection hanging from the centre of the vestibule. The posterior part of the urethra resembled a thin-walled muscular tube. Complete laceration of the perinæum.

after described, the result will not prove satisfactory to the patient, and the outcome will be the ordinary miserable, non-sustaining perinæum, resulting from most operations for its repair.

The operative field is denuded as seen in the sketch, and the first four interrupted sutures placed in each acute angle

FIG. 2.

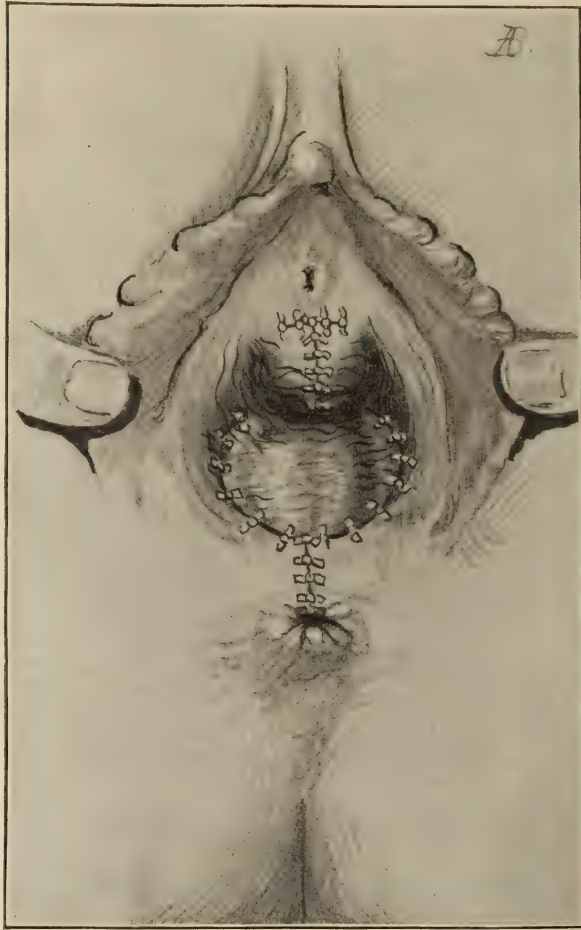


Illustrating denudation for repair of urethra and perinaeum with sutures in situ.

are of number two catgut. Now come the main sutures, three in number, of silkworm-gut. If the denudation at this point is

not deep enough to expose the fibres of the anterior border of the levator ani muscle, the knife should be taken, and the dissection continued until the muscle is exposed; then introduce the needle straight out towards the lateral wall of the pelvis,

FIG. 3.



Denuded areas brought together with sutures tied.

taking in a large circle, and going through the levator muscle to the periosteum, then coming around towards the denuded area and crossing it at the bottom of the cavity, thence upward through the mucous membrane of the projecting central tongue. Two more sutures are put in, following the same course, about

1 centimeter apart, when the tip of the tongue is reached. With these, the vagina along this tongue is vertically hung up on the lateral muscular pillars of the levator muscle. (Fig. 2, A.) The next, which is the crown suture, is also of silkworm-

FIG. 4.



Appearance three weeks after operation.

gut, and is a superficial suture in its passage through the tissues, and takes in the tip of the projecting tongue of mucous membrane. When this suture is tied it brings up the tissues adjoining the tip, and makes this point the highest of the lower

vaginal wall, and also replaces, in a measure, the posterior commissure.

The remaining three or four sutures are of number two chromicized catgut, and extend from side to side, reaching the bottom of the denuded space anterior to the tongue of mucous membrane. This brings us to the sutures which are placed to restore the sphincter ani muscle. The dimples on each side are carefully observed as evidence of the location of the ends of the muscle, and sutures are carefully introduced to approximate these ends, thus restoring the function of the sphincter. These are the first tied, and are followed by building sutures above; then, beginning at the upper angles, all the sutures are tied, bringing the parts into apposition, as shown in Fig. 3.

Following the operation, a self-retaining catheter was used for six days, and after its withdrawal the patient urinated normally five hours later. The rest of the convalescence was uninterrupted. The sutures were removed on the fourteenth day, and primary union secured. Fig. 4 shows the anatomical relationship of the parts after healing had taken place and the sutures were removed. In commenting upon this rare urethral injury, I am aware that for the urethra to be so freely torn from its bed of connective tissue, with which it is intimately blended, seems almost impossible; but the picture is true to the case.

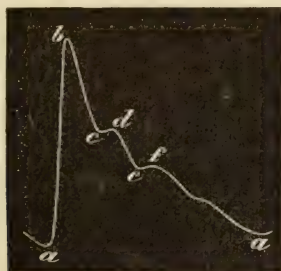
THE USES AND LIMITATIONS OF THE SPHYGMOGRAPH.

BY CLARENCE BARTLETT, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of Western New York, April 11, 1902.)

MUCH prejudice exists against the use of the sphygmograph in the study of pulse characteristics. It is charged against the instrument that its use takes time, and that its findings are unreliable. If the instrument is reliable, the fact that its use does take time should count for naught, for time spent in the study of disease is never time wasted. But I contend that if one will but systematize his methods, he will find that the time consumed in making the observation is not as great as that occupied in taking the temperature. In fact, the physician

may readily adjust the instrument and make the tracing while waiting for the thermometer to attain its maximum reading. As to the charge of inaccuracy, much depends upon the knowledge possessed by the observer and the manner in which he uses the instrument, and his conceptions of the value of his observations. He must not expect that a sphygmographic tracing will give him pathognomonic symptoms, nor should he expect to attain perfection with twenty-four hours' experience. If he does, he will surely be disappointed. Its findings must be studied in conjunction with the information obtained by palpation of the pulse, the physical examination of the heart, and the general condition of the patient. Studied in this light, there are numerous occasions in which the sphygmograph will be found invaluable. I am fully aware that high authorities



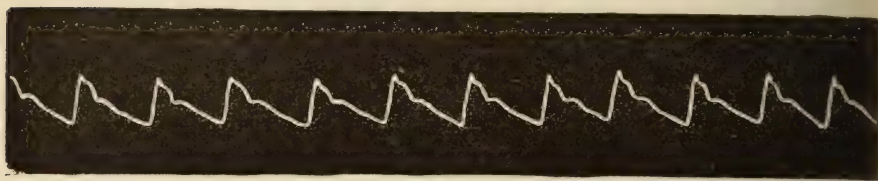
Typical pulse-wave. (After Sansom.)

condemn the instrument as practically useless. One of these, in a recent discussion, asserted that the sphygmograph could be applied to the patient's wrist and maintained there by the hand of the examiner. If it is his regular practice to so use the instrument, I am not surprised that he should entertain such a low estimate of its value.

Numerous sphygmographs have been invented; but that of our own Dudgeon is the simplest, the most reliable, and the most portable. It is therefore, *par excellence*, the best adapted to clinical use. The mechanism of the instrument can be seen at a glance. The attempts at modifying it have not been successful in making any great improvement. Richardson's modification by producing lines by which the relative positions of the different portions of the tracing may be seen at a glance is convenient, but it can scarcely be regarded as anything more.

The patient may be examined either lying, or sitting with the arm supported. The position of the radial artery must first be determined accurately. The button of the sphygmograph should next be placed carefully over the same, and the instrument must then be secured firmly in place by strapping it to the wrist. This last procedure is absolutely essential, as in this way only can an even pressure be maintained.

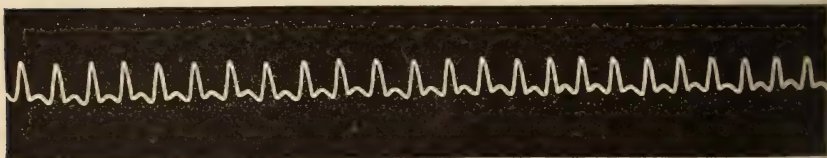
The sphygmograph being *in situ*, there should appear at once



Normal tracing.

regular excursions of the tracing-needle. If they do not so appear, then careful extension of the hand on the forearm or regulation of the button-pressure by the little eccentric lever of the instrument will cause them to become manifest. The novice at once asks, "How much pressure? How much extension?" To this I reply, the position and pressure which will give the most marked oscillations of the needle.

The tracings should be taken on slips of a smooth-surface

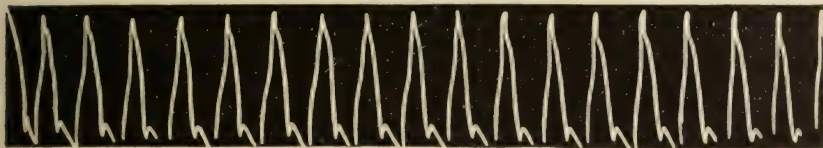


Low tension pulse. Chronic myocarditis with chronic interstitial nephritis. Sudden death during course of Schott treatment.

paper well blackened with lampblack. To prepare these, a slip of paper should be placed in one of the tin holders belonging to the outfit, and then held over a piece of burning camphor until evenly smoked.

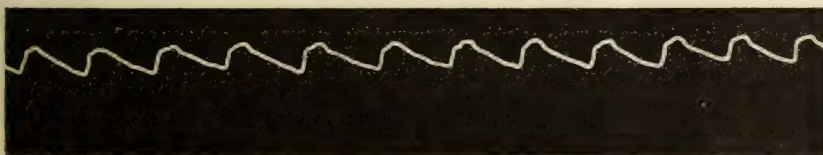
After the tracing has been made, it can be rendered permanent by immersing it in a solution of gum dammar in equal parts of gasoline and benzine. This dries in a few seconds, and can then be filed among the records of the case.

The intelligent use of the sphygmograph demands, first, that the observer understands the character of the information it is capable of giving. This may be summed up in a few words: It gives an accurate record of the variations of arterial tension. The factors which bring about these variations in tension include the volume of blood thrown into the arteries with each ventricular systole, the steadiness with which this column of blood is maintained in the blood-vessels by the force of the left



Aortic regurgitation.

ventricle, the apposition of the aortic valves, the elasticity of the arteries, and the resistance of the arterioles and capillaries. It enables us to discriminate between apparent and real strength of the pulse-beats. It makes an accurate and permanent record of irregular pulsations, thus particularizing for leisure study pulse-qualities which cannot be observed off-hand by palpation. It gives us an accurate conception of the state of elasticity of the arteries. In the presence of an aortic systolic murmur, it



Aortic stenosis ; inelastic arteries.

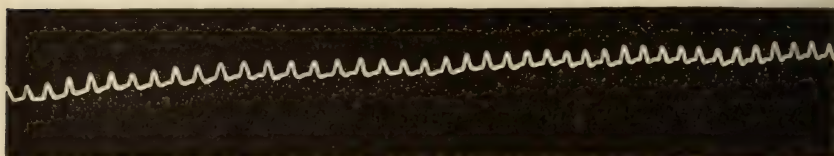
enables us to determine positively whether such murmur is or is not dependent upon aortic stenosis.

The normal sphygmogram is made up of the following parts :

1. An upstroke (*a b*), which may be called by this title, or by the name proposed by Sausom, "the chief ascending wave."
2. The terminal angle of this upstroke, generally known as the *percussion* or '*summit wave*.'
3. A notch varying in depth in different tracings.

4. A secondary wave, known as the *tidal wave* (*d*).
5. A notch known as the *aortic* or *predicrotic notch* (*e*).
6. A wave, more or less marked, called the *dicrotic wave* (*f*).
7. The base line (*a a*).

1. *The Chief Ascending Wave*.—Sansom proposed the name of "chief ascending wave" for the upstroke of the sphygmogram because this title did not express any theory as to the forces giving rise to it. It is produced by the contractions of the left



Paroxysmal tachycardia. Arrhythmia between paroxysms. Paroxysms last from two to three hours to as many days. In this attack, pulse 200 per minute for four hours.

ventricle. Normally, it should be nearly perpendicular; but when the ventricle is weak, the aortic orifice narrowed, the walls of the arteries diseased, or the vascular resistance increased, it departs from the vertical, and becomes more or less slanting. At the same time the summit of the tracing becomes more or less flattened, partly because of the retarded discharge of blood into the arteries, and partly because of the diminished momen-

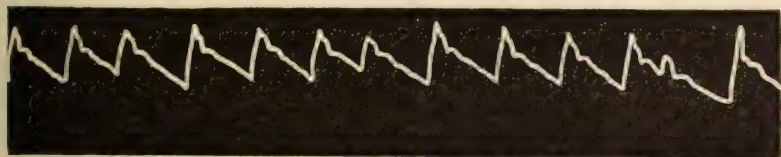


Dropped beat; chronic myocarditis. Broad summit with well-marked dicrotic notch.

tum of the writing-needle in response to the distending force. In the case of aneurysm, the abnormal slant is observed on one side only. The aneurysm acts as an elastic bag, which, equalizing the propelling force of the left ventricle, causes the differences in arterial pressure between systole and diastole to be emphatically less evident.

Referring to lack of symmetry of the tracings over the two radial arteries, too much reliance must not be placed upon this

symptom as evidence of aneurysm, for it may arise from other causes pathological in character, or it may be the result of inexperience in the use of the sphygmograph. Thus it may be due to unilateral vaso-motor changes, as I once noted in a case of brachial neuralgia; to lack of vascular symmetry; to the deeper situation of one radial artery, etc. Asymmetry of tracings must, then, be regarded as simply suggestive of aneurysm, and not diagnostic or in any sense pathognomonic. Of course,



Irregular arrhythmia.

if one of the sphygmograms presents the characteristic features present in aneurysm, then the observation becomes of increased value. Even here one must not be too sure, for cases have been observed in which the tracing on the affected side presented greater amplitude than normal—a phenomenon that has called forth a variety of explanations, none of which have been fully accepted.

As to the slanting of the upstroke as the result of aortic stenosis, increased vascular pressure, etc., its consideration is



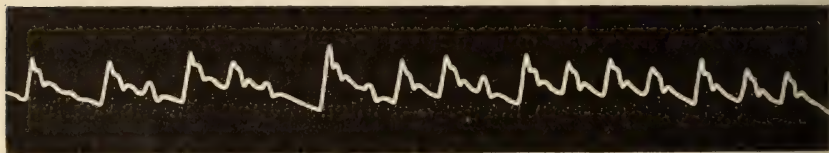
Weak pulse ; myocarditis.

deferred until I come to speak of the sphygmographic evidence of these conditions.

The chief ascending wave may slant unduly by reason of a thick layer of fat between the artery and the button of the instrument.

It would *seem* that the height of the chief ascending wave must always vary with the force of the left ventricle. This, however, is not so, because of the variable conditions against which the ventricle is obliged to work. Thus, with diminished

arterial pressure the line will be higher than normal; in the presence of high tension, it will be lower. When the contraction of the left ventricle is sudden, and the resistance is not increased, the recording needle will, because of the play in the levers moving it, be forced ahead at a greater speed than the distention of the vessel, and will attain a higher point than it could with the same degree of distention less suddenly exerted. Height of upstroke, then, is to be regarded more as evidence of the suddenness with which the left ventricle is emptied than of strength. This statement is not an absolute one, and hence must be remembered in practice as subject to exceptions which will be suggested by the associated conditions. The quantity of blood forced into the arteries with each systole is an important factor in modifying the amplitude of the upstroke. Thus, in mitral disease, the quantity of blood entering the aorta being small, this portion of the tracing is correspondingly scant.

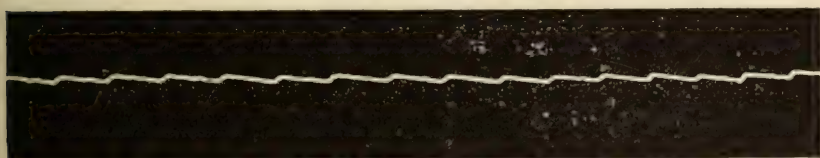


Arrhythmia showing linked beats.

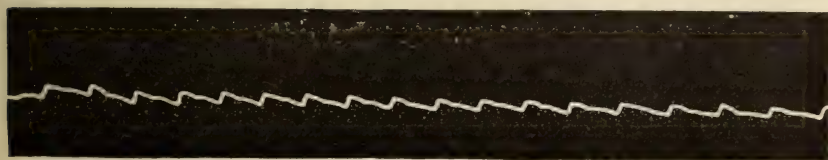
2. *The Percussion Wave*.—As stated in the preceding paragraph, the play in the parts composing the levers moving the writing-needle permits the latter to be forced ahead of the dilating artery. When the needle has lost its momentum, it falls by its own weight, forming an acute angle at the summit of the tracing. It continues to fall until it reaches the artery again, and then it is forced upward once more, the act last mentioned thus producing the tidal wave. In other cases the needle keeps company with the artery throughout the expansion of the latter, so that it descends without the recoil marking the tidal wave. Such is to be observed in the normal pulse.

3. *The Tidal Wave*.—Normally, the tidal wave is below the summit wave. Sometimes, however, the reverse condition obtains, and the tidal wave is higher than the summit of the percussion upstroke, and becomes rounded. We call this the *anacrotic pulse*. There may or may not be a notch between the

percussion and the tidal waves. When a tracing exhibits anacrotic character, care should be taken that the observation is correct, for it is very easy to secure such a result by exerting too much pressure upon the artery. It is observed in cases of increased intravascular pressure, atheromatous arteries, and aortic stenosis. To use Sansom's words, "It indicates a prolonged effort on the part of the left ventricle against an obstruction, but it rather shows that the ventricle is equal to the increased labor. When the ventricle fails, the bulging of the tidal wave is no longer observed, the summit of the tracing becomes flat, and dicrotism, which we consider to have an un-



Right pulse.



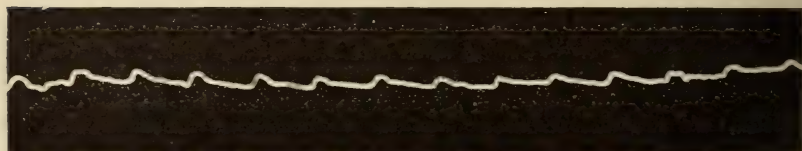
Left pulse. Weak heart action in inordinately stout young subject; probably extensive fatty infiltration of heart; patient liable to paroxysms of cardiac syncope; difference in two tracings due to different thickness of covering of radial arteries by soft parts.

favorable significance, may be manifested." The tidal wave is small or absent when the heart is weak, when a strong heart is acting with full peripheral circulation, and in cases of aortic or mitral incompetency.

4 and 5. *The Aortic Notch and Dicrotic Wave.*—These are well marked in the normal pulse-tracing, their situation being as indicated in the figure. The aortic notch marks the precise moment at which closure of the aortic valves takes place, and the dicrotic wave results from the rebound of the column of blood from such closure. The diminution or obliteration of these portions of the sphygmograms are hence easily understood. Thus, in cases of aortic regurgitation, the influence of

the closure of the valves is decidedly less prominent than normal, if, indeed, the notch and the subsequent wave do not disappear entirely. In cases of increased intravascular pressure they are almost entirely obliterated, and what remains of them occupies a much higher position in the tracings than is normally the case.

It is well to bear in mind that increased vascular tension may be brought about by two conditions: (1) increased ventricular action, which we may call systolic tension, and in which case the notch and the wave occupy a relatively low position; and (2) increased arterio-capillary resistance, which produces post-



Inelastic arteries in woman, aged 35. For three years subject to chronic diarrhoea. 15 to 25 stools daily. Recovery for past year. Lower tracing taken under greater pressure than the upper. The irregularity is due to unsteadiness of the patient's hand.

systolic tension, which is characterized by a high position of the aortic notch and dicrotic wave.

When the dicrotic wave is a prominent feature, we speak of the pulse as dicrotic. When the aortic notch descends to the base line, we say there is full dicrotism; when it falls below the base line, we designate the pulse as *hyperdicrotic*.

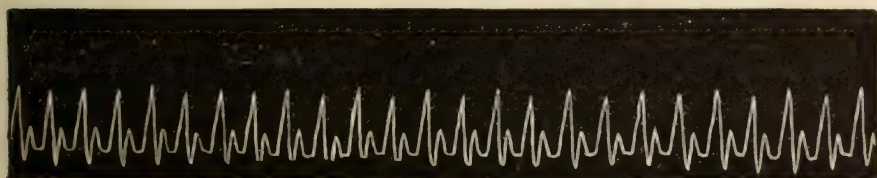
Full dicrotism is observed in the low-tension pulse of fevers, especially in typhoid fevers. Still, it may be present in all conditions characterized by low vascular pressure.

Exceptionally, dicrotism may be observed apart from low tension. Thus, in cases with normal blood-pressure, the left ventricle, by contracting suddenly and forcibly, may lead to a very energetic rebound on closure of the aortic valves, thus producing a correspondingly distinct dicrotic wave.

Dicrotism is sometimes observed in tracings presenting a broad summit. In such instances there has previously existed high-pulse tension, and the arterial walls have undergone changes; but, owing to vascular relaxation, the dicrotic bound takes place.

Sphygmographic Evidence of High Arterial Tension.—The tracing of high-pulse tension exhibits a slanting upstroke, a broad summit, the tidal wave may be higher than the percussion wave, and the aortic notch and dicrotic wave are greatly diminished in amplitude and occupy a higher position than normal. When the high tension is due to vigorous ventricular action (systolic tension), the patulousness of the arterioles and capillaries being normal, the dicrotic wave and the preceding notch will occupy a low position.

Sphygmographic Evidence of Low Tension.—In the case of low vascular pressure, the characteristic features of the tracing are



Hyperdicrotic pulse, an unusually fine example. (After Goodno.)

brought out by light or moderate pressure of the spring of the sphygmograph. Increasing the pressure produces weakness of the movements of the system of levers; exactly the reverse condition obtains in high arterial tension. The upstroke is nearly vertical and high. The summit wave is pointed; the tidal wave is usually prominent, and full dicrotism, or even hyperdicrotism, is observed.

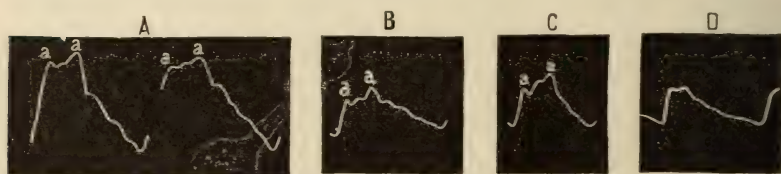
Sphygmographic Evidence of Aortic Stenosis.—The left ventricle discharges itself slowly in cases of aortic stenosis. The upstroke is therefore slanting, and does not attain a great height. The summit of the tracing is broad or anaerotic. Dicrotism may or may not be absent; usually, however, it is absent. The indications simulate closely the signs of high tension.

Sphygmographic Evidence of Aortic Regurgitation.—This condition produces the “water-hammer” pulse, also known as Corrigan’s pulse. It is characterized by a prolonged vertical up-

stroke, sharp apex, and a rapidly-falling downstroke, interrupted or not by a slight break marking the place where the aortic notch and dicrotic wave should appear.

Sphygmographic Evidence of Combined Stenosis and Regurgitation at the Aortic Orifice.—The effect of these lesions combined is to give a tracing in which one element tends to neutralize the influence of the other. Nevertheless, when aortic regurgitation is well marked, the tracing exhibits to a certain extent the characteristic collapsing character, and the pulsations of the radial artery may be visible. Other than this, no regular rule can be formulated.

Sphygmographic Evidence of Mitral Regurgitation.—Concerning this subject, we have a most excellent example of the great differences in opinions held by high authorities. Thus Broadbent declares that this is the one lesion above all others capable of



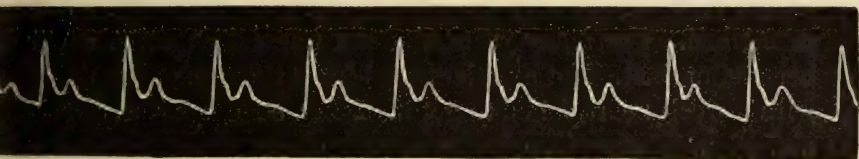
Anacrotic pulse. (After Landois and Sterling.)

producing irregularities of the cardiac rhythm, while this is strenuously denied by Balfour, Sansom, and Whittaker, who assign an equal prominence in favor of mitral stenosis. All are united in stating that, so long as compensation is maintained, the cardiac rhythm remains regular in mitral insufficiency. Irregularity of the pulse in connection with mitral insufficiency may be said to occur only when there is co-existent pulmonary disease or failure of compensation with dilatation of the right heart. The tracings exhibit certain well-defined additional characteristics. Low tension is evident in the majority of cases, hence the dicrotic wave is well-marked. Owing to the diminished volume of blood forced into the arteries (part of the ventricular contents being forced back into the left auricle) with each systole, the amplitude of the upstroke is small. At the same time, auscultation discovers an energetically-acting heart in striking contrast with the weak pulse.

Exceptionally the tracings show increased vascular tension.

Such instances may occur in connection with chronic renal disease. The sphygmograph affords valuable means of differentiating cause and effect. Thus, in the case of associated renal disease, the problem may be the determination of the influence of prolonged vascular pressure upon the mitral valves causing regurgitation, or the discovery of valvular disease antedating the renal complication. In the former case, the tension will be high; in the latter, low. Taking, again, the case of anæmia in mitral regurgitation, the important question is the organic or functional origin of the mitral murmur. In anæmia the pulse tension is increased, which feature is not altered by the co-existence of a functional mitral regurgitation. If the lesion is organic, the tension, on the other hand, will be low.

Sphygmographic Evidence of Mitral Stenosis.—The pulse of mitral stenosis may be either regular or irregular. In either case it is of small amplitude, and exhibits evidence of increased tension.



Dirotic pulse of typhoid fever. (After Goodno.)

In many instances irregularity may constitute an early sign of failing compensation. When not present, it may be provoked by slight muscular exertion. The irregularity may partake of almost any type; for, indeed, every possible form of arrhythmia may be observed in the same case. At the same time, it has been especially noted that secondary ventricular contractions (*linked beats*) impress themselves upon the downstroke.

In arrhythmia the findings of the sphygmographs are especially interesting, even though, in the present state of our knowledge, they do not enable us to make a diagnosis or offer any important suggestions as to treatment. Undoubtedly, prolonged clinical investigations will relieve the subject of much of its present obscurity; until then, let it be our duty to observe and reason. The finger, at the most, can only recognize irregularity and intermittence. It cannot discern the finer variations in rhythm, as link-beats, or make comparisons between the characteristics of anomalous pulse-waves. Did time permit, it

would be interesting to enter into the subject of arrhythmia, especially as related to prognosis; but this is a subject of itself.

If I were asked to sum up the advantages of the systematic use of the sphygmograph, I would say that it is an invaluable educator of the finger, and it gives us permanent records which enable us to compare conditions of the past with those of the present. In aortic stenosis, the rounded or flat summit is an essential symptom to make the diagnosis certain, for every aortic systolic murmur is by no means dependent upon narrowing of the aortic orifice.

A thorough examination of the pulse involves attention to the frequency, regularity, strength, tension, character of the beat, and the conditions of the arteries. How often, let me ask, do the most careful of us pay any attention to all of these factors? And yet they are all of importance. That they are too often ignored is demonstrated by the manner in which heart tonics, vaso-dilators and vaso-constrictors are indiscriminately prescribed. For many years digitalis reigned supreme as *the* heart stimulant. Not a patient with heart disease, or one dying with a weak heart, failed to get it. Later, strophanthus, strychnia, glonoin, atropia, adrenalin, and other drugs, secured a large share of professional favor. From personal observation, I would say that these various drugs have been administered more by reason of the individual prejudices of the prescriber than upon any rational basis.

How often does one see a patient dying with the general exhaustion attendant upon cancer, tuberculosis, nephritis, and other incurable diseases, dosed *ad nauseam* with cardio-vascular stimulants without rhyme or reason. These drugs seem to be used for the mere sake of appearing to do something, rather than in the hope that they can even palliate. When death has ended the scene, as it always does, it is exceptionally, only, that the physician can look back with any satisfaction at such helter-skelter methods.

Digitalis should be eliminated entirely from the list of drugs to be administered in cases of heart-failure. It is a true heart-tonic, increasing the action of the heart-muscle and raising vascular tension. Its action causes the heart itself to become better nourished, thus improving it in every way. The benefits to be derived do not arise from its stimulating properties on

the heart. The best results are to be secured by giving moderate doses over a comparatively long period, watching most carefully from day to day the state of the circulation. Digitalin, though not infrequently prescribed, is a remedy better let alone. It certainly does stimulate the heart, but to what purpose? To the same purpose, let me answer, that follows the whipping of a jaded horse to get him over a limited stretch of road. It is all right if the horse has sufficient strength to carry him to his journey's end, but he is undoubtedly weaker than he was before the stimulation was applied. And so it is with the heart. Too often we overwork a jaded heart,—and the patient dies.

And so we have been led to abandon digitalis and employ the vaso-dilators, of which glonoin and amyl nitrite are representative members. And, if these drugs are properly indicated, let me say that there is no prettier example of successful treatment than the results following their administration. But *they are indicated only when vascular tension is increased*. Hence they are useful in angina pectoris, uræmic asthma, interstitial nephritis, and many cases of arterio-sclerosis. *Amyl nitrite* is adapted to cases requiring prompt results and short action. *Glonoin* does not act so quickly, but its action is more prolonged. *Erythrol tetranitrate* exerts very similar action to glonoin, and may be given satisfactorily at long intervals over a prolonged period of time. This class of drugs relieves by reducing the arterio-capillary resistance to a normal standard, thus enabling the heart to work against less burdens.

Serious results may follow decreased intravascular pressure, and let me say that this class of cases constitutes the majority of cases of heart-failure. The remedies to be administered in the emergency include strychnia, atropia, and suprarenal capsule. For several years past strychnia has been a very popular medicine—popular beyond all rhyme and reason. Acute and chronic diseases are alike treated by it, the one indication being failing circulation, the cause therefor being entirely ignored. So far as any action on the heart itself is concerned, strychnia may be regarded as practically valueless. But it is beneficial in enabling the heart to act to better effect when blood-tension is low. This action is greatly intensified when the drug is combined with atropia, the dosage being one-sixtieth of a grain of

strychnia with one two-hundredth of a grain of atropia, repeated not oftener than every six hours. The atropia is especially valuable when there is associated œdema of the lungs, though, with such a serious condition present, it is unusual for any medicine to secure any permanent result.

Suprarenal extract probably stands pre-eminent as the remedy in conditions in which the heart is acting against greatly diminished peripheral resistance. Three times, now, have I seen cases in which life has been certainly saved by the prescription of this remedy. Three to five grains of a reliable extract (Armour's was used in my cases) may be given every six hours. In a case of suddenly appearing dyspnœa in a patient with interstitial nephritis and dilated heart, a single dose of three grains brought prompt amelioration. The other cases referred to were of failing heart succeeding abdominal section.

In the failing heart of acute diseases, the hypodermic injection of camphorated oil is by all odds the best remedy. One part of camphor should be dissolved in nine parts of sterilized sweet oil. Of this, 15 minims constitute a dose.

Heart-failure comes from such a variety of causes that it is a difficult matter to formulate rules for the management of all cases. Indications must vary according to the etiological factors. In many instances drugs are not necessary. Much can be done by the application of heart-cloths to the præcordium. In chronically weak heart with dilatation, the cardiac muscle will regain greatly in tone and strength, the dilatation receding, by the employment of the faradic brush over the heart for two or three minutes, twice daily.

ASPIRATION-SUCTION IN THE EXTRACTION OF THE CRYSTALLINE LENS FOR MYOPIA.—Truc, of Montpellier, encouraged by the simplicity and success of the aspiration of ordinary traumatic cataracts, has employed the method in order to remove the lenses in four myopic eyes. He has found that after one or more discissions the provoked operative cataract can be easily and usually completely removed. The operation, when done aseptically, has no serious complications, and has given him better results than either the simple or the combined methods of extraction. The procedure is to be especially recommended for relatively young subjects with annular or soft nuclear cataracts.—*La Clinique Ophthalmolog.*

THOUGHTS ON THE STUDY OF THE MATERIA MEDICA.

BY A. B. RICE, M.D., JAMESTOWN, N. Y.

(Read at the Annual Meeting of the Western New York Homeopathic Medical Society, Buffalo, N. Y., April 11, 1902.)

QUITE often, in our medical journals, we run across articles discussing the topic, "How shall we study the *materia medica*?" Some of these articles have been written by our best men, professors in our medical schools; but we are compelled to confess that the question has not yet been answered—at least, so satisfactorily answered as to remove the difficulties that hedge the work of mastering our voluminous *materia medica*.

I do not flatter myself that, in this paper, I shall be able to answer this question; indeed, it is with fear and trembling that any attempt in that direction is made.

My purpose is simply to give some very commonplace thoughts upon this confessedly difficult but supremely important subject—some suggestions that have been helpful to me, and in the hope that they may also be of use to others.

It is unnecessary to state that a complete mastery of the *materia medica* is impossible. By this statement it is meant that it is impossible for any one, no matter how retentive his memory, or how close and long-continued his application, to learn and carry in mind the multitudinous symptoms of our now greatly enlarged *materia medica*.

Think of trying to memorize the "Guiding Symptoms" of Hering, or Allen's "*Materia Medica*!" Or take some of the smaller works, as Allen's "*Hand-Book*"; the task would be interminable! Take still smaller works, as H. C. Allen's "*Key-Notes*," or the "*Pocket Manual*" of Wm. Boericke, and we shall find that we still have no small task on hand. Indeed, it would be so great a task that few would be able to say, "I have accomplished it."

The symptomatology of our remedies is so great that we are almost overwhelmed!

Is there any way to gain such a practical working-knowledge of the remedies we use as to be able to carry it in mind, and to prescribe accurately, off-hand, at the bedside and in the office?

If there is not, if we can only prescribe accurately after a careful writing of all the symptoms, according to the directions given in the *Organon*, and then an equally painstaking study of the remedy by means of a repertory and checking-list, then let us mourn for the great body of scientific homœopaths who have been making such a stir in the world for the last hundred years.

Here let me say that I would not cast a shadow of doubt upon the value of Hahnemann's work, or belittle the importance of the suggestions he has left on record for our guidance. Rather, all honor to him for a glorious work done in a benighted age, in the face of almost insurmountable obstacles.

But in our work emergencies arise; quick prescribing becomes necessary; in the presence of an hæmoptysis, a post-partum hæmorrhage, an hepatic or renal colic, or acute pain of any sort, we must act at once, and act efficiently, if we would be worthy the honored name we bear.

How can we do this, if not prepared beforehand by at least a working knowledge of the remedies we claim to have in abundance in the materia medica?

Take any acute disease, as pneumonia, dysentery, cholera morbus, and there are few of us who would take the case *a la* Hahnemann, and then work out the remedy with repertory and checking-list.

Hence the importance of the question under discussion: Is there a better way to learn the therapeutics of our remedies than the old way of memorizing symptoms arranged according to the Hahnemannian Schema? Must we learn first the symptoms under *mind*, then head, eyes, ears, etc., ending with the skin?

It is certain there ought to be some other way, for who of us is able to learn materia medica in such a way? He who shall point it out to us will be justly entitled to the same honor we bestow upon our illustrious founder. The thousands who may follow us in the work of our profession will rise up and call him blessed.

In this connection, allow me to give a few quotations showing how some of our leaders feel upon this subject.

In the preface to his "Leaders in Therapeutics," Dr. Nash gives as the reason for writing a book the following:

"To fasten upon the mind of the reader the strongest points of each remedy. Good off-hand prescribing can be done in simple, uncomplicated cases, if we have fixed in our minds for ready use the characteristic symptoms."

H. C. Allen, in the preface to his "Key-Notes," uses the following language:

"To enable the student or practitioner to do this correctly and rapidly" (select the *similimum*), "he must have as a basis for comparison some knowledge of the *individuality* of the remedy; something that is *peculiar, uncommon*, or sufficiently *characteristic* in the confirmed pathogenesis of a polychrest remedy that may be used as a pivotal point of comparison. Something of this kind seems indispensable to enable us to intelligently and successfully use our voluminous symptomatology."

Dr. Wm. Boericke, in the preface to his "Pocket Manual of *Materia Medica*," says:

"For many years the author has felt the need of a pocket edition of our *materia medica* containing the characteristic and cardinal symptoms of all our known remedies, arranged according to the Hahnemannian Schema for ready reference."

These quotations seem to show that there is a "*long-felt want*" for some better way to learn the therapeutic action of our remedies than has hitherto been followed.

Permit me, therefore, to give a few thoughts or suggestions that have been helpful to me, as I have tried to comprehend the therapeutic action of the remedies in our great armamentarium.

1. Is it not true that most of the remedies in common use have an *individuality*, as Dr. Allen calls it, that serves to distinguish them from all others?

It is the *red strand*, as it has been called, that brings plainly to mind the place in the therapeutic field the remedy occupies.

It has also been called the *genius* of the remedy, the *grand characteristic*; but by whatever name we speak of it, there is *something*, if we can only find it, that gives it such a character that it stands out, clearly defined, with an entity all its own.

Allow me to say, here, that I do not mean we are to re-

gard *characteristic symptoms*, so often mentioned by our writers, as the thing to be sought in our study of the *materia medica*. It is more than this.

I believe characteristic symptoms to be of great use to us; they are guide-boards pointing the way to the remedy; but is it not possible to become so imbued with the individuality of a remedy as a whole that it will stand clearly outlined to the mind, like some tall mountain peak outlined against the sky?

2. To illustrate more fully my meaning, let us look at a few remedies as examples. As the first, let us take the remedy almost always studied first by the students of *materia medica*: *aconitum napellus*.

We find running through all its symptoms this red strand: *anxious fear*.

In all the mental symptoms there is anxiety and fear. "The countenance is expressive of fear; the life is rendered miserable by fear;" there is anxious restlessness; all the pains, whatever they may be, are accompanied by the anxious fear; the fever always has "intense nervous restlessness, tossing about in agony." H. C. Allen says: "This mental anxiety, worry, fear, accompanies the most trivial ailment." Hahnemann says: "Whenever aconite is chosen homœopathically, you must, above all, observe the mental symptoms, and be careful that it closely resembles them; the anguish of mind and body; the restlessness; the disquiet not to be allayed." It is useless to prescribe aconite when this characteristic is wanting.

It is probable that no remedy in the *materia medica* is more often wrongly prescribed.

What, then, is the mental picture of this grand remedy? Remember the *anxious fear*, and the whole symptomatology will fall into line. How does it differ from arsenic, which has anxious fear also?

The *acuteness* of the symptoms, so to speak,—their *sthenic* character,—marks the difference between them. Ars. is *asthenic*; aconite, *sthenic*.

Take another, and totally different example: *pulsatilla*.

This is the *mild, gentle, yielding* medicine. Hence it is the woman's remedy (as nux is the man's.) She is sad, cries readily; is changeable, contradictory; the symptoms are ever changing, because she does not have the firmness to control

them; she yields to every impulse; the discharges are thick, yellow, and bland, because the whole condition is in accord with that kind of discharge; she is better in the open air, from motion, etc., because she is thus stimulated, roused out of her prevailing condition. It is often the remedy for girls at puberty because they then exhibit the mild, yielding, tearful disposition.

This gives us a fair picture of *pulsatilla*, to which you may add as many special symptoms as you please.

Possibly some one may say, these are simply mental symptoms you have selected, and unworthy the prominence given them.

Let us take another example, and that objection will not apply. We select *belladonna*.

There is most emphatically a bright-red characteristic running through its symptomatology, like the stain of its own berry. It may be expressed in one word: *congestion*.

Do we have a headache in which *belladonna* is indicated? If so, we have a red face, glistening eyes, throbbing pain on lying down, all of which is covered by the one word, *congestion*. Is it an erysipelas? Then there is the bright-red surface, swollen capillaries, heat of skin, *congestion*. Is it scarlet fever? Then there must be the intense fever, congested throat, extreme surface-heat, and universal bright redness of the skin.

Do we ever think of *belladonna* in slow, chronic cases? The picture is rather the exact opposite, and we will do well if we remember and use it as the *congestion* remedy, *par excellence*.

Call to mind *arnica*, and you think at once of wounds, bruises and sprains. Or *hypericum*, and at once torn nerves, and injured nerve-tissue, whether in brain, spinal cord, or finger-tips, come instantly to mind, and we find no difficulty in defining its sphere of action.

We may select one of our later remedies, and, although it has come into use by a breech presentation, as Hering would say, not having been proved, yet it has come to stay. It is *echinacea*. Its grand characteristic is its control over sepsis. No matter whether it be a case of puerperal sepsis, gangrene, carbuncle, any septic condition whatever, we are rapidly learning that it is a remedy of great value.

“*Nux vomica* is chiefly successful with persons of an ardent

character; of an irritable, impatient temperament, disposed to anger, spite or deception." (Hahnemann.)

Hence, nux patients are oversensitive; noise, odors, light, music, trifling ailments, are unbearable. Even the constipation of nux is caused by irregular, over-excited peristaltic action; the dyspepsia of nux is most often the result of stimulants or narcotics, which have produced an irritable, irregular action of the stomach in perfect harmony with the general nervous character of the remedy.

But some one may say, "You cannot prescribe upon one characteristic alone. All the symptoms of the remedy must be considered." True. But suppose that characteristic is the one grand, controlling characteristic that pervades every other symptom, and runs through the whole symptomatology from beginning to end? Then it would be safe to rely upon that, because that is the whole remedy in a nutshell.

I will not attempt an analysis of *rhus tox.* and its relation to fibrous tissue; or of *podophyllum*, which acts so strongly on the liver and gastro-intestinal canal; or of *chelidonium*, the magnificent liver remedy; or *chamomilla*, with its spiteful sensitiveness to pain, only to suggest that they, with most of our remedies, may be found to possess an individuality so marked that it might be expressed in a single phrase or a few terse sentences, and thus be the more easily brought to mind in the time of need.

The truth designed to be illustrated and impressed in this paper is this: Each remedy in our materia medica has a special field of action, that stamps it with an individuality all its own. Study each remedy so as to bring out clearly its individuality, its genius, its grand characteristic; and remember this, rather than attempt to memorize the multitude of symptoms gathered from the provings.

Perhaps some one may ask, "Of what value, then, are the provings, with their multitudinous symptomatology?"

Much, every way. Without them we could never learn the special character of the remedy. The provings give us the key that unlocks the door to the individuality of the remedy. We must study them until we see the picture hidden therein, and then use the picture, not the framework that contains it.

Now, having the picture, the genius, the individuality of our

remedies clearly in memory, we are prepared to meet successfully all cases, emergency or acute, as they come to us; and we may go on in the future, as in the past, "conquering and to conquer."

In closing, allow a word as to the helps best adapted to assist in gaining such a knowledge of our materia medica.

The best work yet written, in my judgment, is Nash's "Leaders in Therapeutics." Its easy conversational style, and a remarkable facility in bringing out the individuality of the remedy, make it invaluable to the student, young or old. Each physician might study out for himself these things; but life is too short, and the work too difficult to be entrusted to unskilled hands.

The "Pocket Manual" of Wm. Boericke, just published, has, as an introduction to the study of each remedy, some practical remarks, pointing out the general scope of the remedy, that are very helpful.

H. C. Allen's "Key-Notes" are valuable, especially in the mental symptoms and the modalities.

I do not need to say that "The Guiding Symptoms" and Allen's "Materia Medica" are the fountains from which we draw our knowledge of the action of remedies; the manuals mentioned are the best interpreters written at this time.

It is to be hoped that soon some modern Hahnemann may arise who will write a book on materia medica that will contain the pictures of our remedies so well defined, so clear cut, and yet so plain, that a few terse sentences, or possibly, in some instances, a single phrase, may so reveal the therapeutic power of each remedy that we may no longer flounder along through the mazes of an interminable symptomatology.

CUPRUM ACETICUM IN PARALYSIS OF THE ABDUCENS.—Dr. Heinigke (*Allg. Hom. Zeitung*) cites the case of a man, æt. 29 years, who was suddenly seized with diplopia, and who failed to show the slightest improvement under the use of electricity and the internal administration of potassium iodide. The paralysis eventually cleared up, under the use of *cuprum aceticum*, first administered in the 3d, then in the 6th, and lastly in the 30th, potency.

THE USE OF PICRIC ACID IN THE TREATMENT OF PELVIC INFLAMMATIONS.

BY ARTHUR W. YALE, M.D., PHILADELPHIA.

OUR text-books and chemistries contain but meagre information concerning picric acid, and this is equally true of medical literature in general. It is prepared by the action of nitric acid on phenols containing the benzene nucleus, and chemically is known as trinitrophenol, with a formula of $C_6H_2(NO_2)_3-OH$. In the laboratory it is used as a test for albumin and the alkaloids.

Until within a few years, however, its value as a therapeutic agent remained unknown. Recently it has been recognized as a potent local application in the treatment of burns, and is now used in most of our large hospitals, in the form of an aqueous solution, applied directly to the burned surface; and it has been unquestionably demonstrated that burns thus treated heal more quickly, and leave a smaller and smoother cicatrix than results from any other local dressing.

Dermatologists are beginning to recognize the value of this drug in the treatment of skin lesions, and especially in those affections which are accompanied by a pruritus. It was the foregoing fact which led the writer to test the value of picric acid, in his clinic, in the treatment of inflammations along the female genital tract.

Erosions of the cervix being somewhat analogous to skin lesions, it was with these obstinate cases that the initial trials were made. Many of these patients had been unsuccessfully treated with the numerous local applications familiar to the gynecologist, but under the action of picric acid the healing was prompt, and in most cases permanent. The best method of application was found to be the dusting of picric acid crystals upon a pledget of cotton, and placing in contact with the undried cervix. These results led to the use of tampons dipped in a saturated solution of picric acid and glycerine, instead of the usual boroglyceride and ichthyol solutions. Here it has afforded more permanent relief than the latter drug, al-

though its analgesic action is somewhat slower. It has been found especially useful in acute congestion not only of the vagina and cervix, but in the uterus and its appendages. In many cases where surgical interference was imperative, but refused by the patient, picric acid has held in check the process, although in many cases this was deep-seated.

Among the most stubborn cases which the gynæcologist is called upon to treat are leucorrhœas. The time-honored method of combating these complaints has been by means of the douche,—bichloride, permanganate and creolin being the favorites. Picric acid in varying strengths was substituted for these; and, in this connection, a fact more interesting to the physician than to the patient should be mentioned. Some patients were found to be extremely sensitive to the action of the drug, and its use in too large quantities produced erosions upon a hitherto unaffected cervix; and in other cases vaginitis developed, with myriads of minute vesicles, accompanied by a profuse and excoriating discharge and intense pruritus. Notwithstanding these unlooked-for consequences, the majority of the cases exhibited marked improvement, the discharge decreasing, and in most instances its excoriating character and the pruritus ceasing after one or two douches. I determined, therefore, to find a better menstruum than a douche for administering the acid, and induced one of our large manufacturing pharmaceutical chemists to make up some suppositories containing picric acid in different proportions, the advantage of the suppository over other methods of application being in the prolonged time during which the medicament is kept in contact with the affected part. The suppository containing three grains of picric acid has proved most efficacious.

The patient is given several of these suppositories, with the instruction to place one as high up in the vagina as possible, after going to bed. In the morning she should be directed to take a hot douche, preferably while in a reclining posture. This treatment may be repeated every night, or at intervals, according to the severity of the case,—every other night in most instances being found sufficient.

The suppositories have a tendency to gravitate to the deepest portion of the vaginal cavity; and, as the vaginal walls are at all times in contact, the medicament is thoroughly spread by

the physiological function over the entire mucous membrane, the excess escaping from the vulva, to be caught upon the napkin which the patient should be instructed to wear to protect herself.

Picric acid contains mucine, and the douchings will be found to contain flocculi thereof, while the vagina is left perfectly clean. It will thus be observed that leucorrhœas of a gonorrhœal origin can be more thoroughly treated by this agent than by bichloride of mercury. Picric acid being a strong antiseptic, and very penetrating, the gonococci not only in the excretions, but those on and in the vaginal mucous membrane, will be killed.

Here, again, the suppositories have the advantage over the douche in keeping this strong germicide in contact with the affected parts during the entire night, and also in keeping the vagina acid, thus inducing the gonococci to come to the surface, instead of burrowing in the glands and membrane to escape the alkaline medium in which they do not develop. A few clinical cases may be cited in corroboration of the foregoing statements.

Mrs. D., aged 47, menopause one and a half years ago. Has had one child and one miscarriage, seven and a half years having elapsed since the latter. Leucorrhœa white, profuse, and excoriating. An examination disclosed atresia of the vagina, anteflexion of the uterus, double salpingitis, and an enlargement of the right ovary. This patient suffered from a severe cystitis also. All symptoms diminished after the use of the first picric acid suppository (3 gr.). The use of the suppositories has been continued every other night, with the result that the patient has steadily improved. It is no more than just to say that this patient had been to seven different clinics of both schools, without any improvement.

Mrs. B., aged 31. Has had four children, and one miscarriage. The entire uterus was enlarged, congested, and "flabby," with a bilateral tear and laceration of the cervix. There was prolapsus due to a rectocele, cystocele, and a badly torn perinæum. This patient also suffered from a profuse leucorrhœa. Her first visit to my clinic was made on October 20, 1899. Boroglyceride and ichthyol tampons were used, iodine was applied to the eroded surface, and permanganate, also bichloride

douchings, were employed, but with slight benefit, the profuse leucorrhœa still continuing. On January 1, 1902, the first picric acid suppositories were given, with directions to use one every night. On the 7th of January the discharge entirely ceased, and there has been none since. The uterus has contracted, the erosion of the cervix entirely healed, and the patient's general health much improved.

Mrs. T., aged 33. Has had two children. A year ago had a double oöphorectomy. There was atresia of the vagina, accompanied by a profuse discharge, the latter causing cystitis. After the first suppository the discharge increased, and the cystitis as well as the patient's general health improved.

TINCTURES—ONCE AGAIN.

BY T. H. CARMICHAEL, M.D., PHILADELPHIA.

AN article on "Tinctures" in the March HAHNEMANNIAN, in which I incidentally referred to some unofficial solutions of dried plants in strong alcohol, known as "fluids," occasioned quite a defence of these preparations by Edward A. Bender, Ph.G., in the May number. His ingenious attempt to claim superiority for them over tinctures deserved a reply, and under the heading "*Fresh- versus Dry-Plant Tinctures*," in the June number, Dr. F. A. Boericke gives good evidence from old-school authorities for preferring fresh-plant tinctures to those made from the dried plant.

Mr. Bender says: "It is absurd, however, to fix a rule, and then declare that in this manner alone can a proper solution of the active principles of drugs be obtained," and then offers preparations invariably made by treating dried plants with strong (95 per cent.) alcohol, irrespective of the fact that in digitalis, for example, two of its active principles, digitalein and digitonin, are soluble in water; so that his preparation would not perfectly represent the digitalis. On the contrary, the Homœopathic Pharmacopœia of the U. S. varies the menstruum to the condition of the plant, and thus the resulting tincture represents all the properties in the plant.

In the case of gelsemium, we are told that a Detroit drug firm made a careful examination of its green-drug tincture, but found it inferior to that made from the dried drug; and then Mr. Bender naively remarks, "That ended the vogue of the green-plant tincture." If, however, we turn to Bartholow (in his "Materia Medica and Therapeutics," p. 672), we read: "Disappointment is frequently experienced from the use of gelsemium preparations, owing to the fact that they are made from dried roots. In the process of drying, even spontaneously, the alkaloid disappears. The most trustworthy preparations are the official, prepared conscientiously from the *fresh root*."

There is little doubt of the truth of this statement, as it can be substantiated by thousands of physicians who use the drug, and it therefore follows that the active principles of the gelsemium must be held in solution by the water (juices) of the plant, and that this is probably done by the presence of other substances which increase its efficiency as a solvent. This latter proposition must be true, because we know that when the gelsemin and gelseminin are isolated from the plant they are insoluble in water (or nearly so). Water plays this rôle in many other plants, and it cannot be ignored in a solution of their constituents for medicinal use. In the words of an old work on "Practical Pharmacy" (Mohr and Redwood, p. 237): "Water, the grand solvent of nature, has a more extensive range than any other fluid. A great number of mineral salts, nearly all the salts of the vegetable alkalies, most of the neutral principles, as gum, sugar, etc., and the vegetable acids, are dissolved by it. *Many organic substances insoluble in an isolated state become so (soluble) by virtue of associated ingredients.*"

Mr. Bender's table of the solubility of the isolated principles of aconite, belladonna, etc., is therefore gratuitous. This much, however, may be said of isolated active principles: that they do not have the completeness of action of the plants from which they were derived (in some instances the action being quite different); in many drugs they have not yet been isolated, several principles occurring in one drug and requiring various solvents for their extraction; and, lastly, that when it is desirable to use them, it were better to employ the pure principle, as it is prepared by the manufacturing chemists (dissolve it in

alcohol, if a solution is desired), than to use a preparation made invariably by treating the dried plant with 95 per cent. alcohol.

A few more words about digitalis, which, he says, Dr. F. Mortimer Lawrence tells him is utterly unreliable when given for its physiological effect in a tincture prepared according to the method of the Homœopathic Pharmacopœia.

Digitalis varies very much in the drug power of different specimens of the plant. It contains at least five or six active principles, two of which, digitoxin and digitalin, are insoluble in water when pure, but soluble in alcohol; two more, digitalin and digitonin, are soluble in water. Sollmann says ("Text-book of Pharmacology," p. 482): "When the principles are mixed, *as they exist in the plant*, the digitoxin and digitalin are taken up by water in suspension, through the aid of the digitonin, so that a 1:10 *infusion* contains two-thirds of the digitoxin of the leaf. (Digitonin belongs to the same group as the active principle of soap-bark, and it emulsifies the two resinous principles, so that they can be extracted from the drug by water.)" I would commend this to Mr. Bender as another evidence of the correct principle upon which fresh-plant tinctures are made, for they are all necessarily made from the principles "mixed as they exist in the plant," and in this particular case contain all the principles of digitalis, although digitoxin and digitalin, in the isolated state, are practically insoluble in water.

It is a well known fact that, in the past, all of the great clinicians have preferred an infusion of digitalis to any alcoholic preparation of the drug, because it is more reliable in its action. In recent years, a discrimination in the kind of physiological effect desired (diuresis, or direct action on the heart) has led to a selection of the infusion or the tincture or fluid extract, for there are certainly differences in the therapeutic action of the two kinds of preparations (aqueous and alcoholic). I take it for granted, therefore, that the physiological effect desired by Dr. Lawrence was upon the heart; for if that upon the kidneys was required, the infusion would have been preferred, because "it contains more of the digitonin, which holds the vaso-constricting effects of the other principles in check, and thus favors diuresis." For this purpose a strong

alcoholic "fluid" is least desirable, as it contains more of the digitoxin, which is most irritating. On the contrary, if the direct action upon the heart muscle is desired, then the alcoholic preparations (tincture or fluid extract) or the powdered leaves are to be preferred. If the digitoxin itself is preferred, it may be used in its purity or by dissolving it in alcohol.

Of the fluid preparations, however, evidence is not lacking of the efficiency of the homœopathic tincture. The following extract from a letter of Dr. J. W. Crumbaugh, of Wilmington, Del., to Mr. C. A. O. Vischer, is in point: "In reference to the tinct. digitalis tablets, would say that there can be no doubt of their therapeutic efficiency. As near as I can measure clinically, I would say that each five tablets represent about the drug efficiency of $\frac{1}{4}$ gr. of the powdered leaves. When given in these doses at intervals of from three to four or five hours, you will get physiological effects in impressionable cases in the first or second day. In the usual ten-drop doses, you will get the same effects in much shorter time."

Other practitioners have had good results from the homœopathic tincture of digitalis; but I must leave this subject to consider a very powerful reason for the appearance of 95 per cent. alcoholic solutions of dried plants. It is that "there exists a demand for active preparations of definite strength which can be used by the homœopathic physician for medicating pellets." On this subject I shall try to talk plainly for Mr. Bender's benefit, and also for that of the homœopathic physicians who are so enamored with medicated globules (a better word than pellets, because some equal, in size, the large pills) that they demand active preparations of definite strength to pour upon them. Globules are a vehicle peculiar to homœopathic pharmacy, and they are admirably adapted for dispensing the attenuations from the 3x upward. They were never designed, and are not adapted, for the dispensing of strong liquids intended to produce physiological effects. They vary in size and in their power of absorption. They are used by pouring the liquids over them, and it is impossible to estimate the quantity absorbed by a globule (in fact, no two doses would be exactly alike). While these points do not detract from their efficiency as carriers of the homœopathic attenuations, they do make them unfit for the exhibition of medicines for physiological effects

where accuracy of dose is a *sine qua non*. Any physician who uses them for such purposes would be a very loose prescriber. There are more exact and scientific ways of dispensing drugs for physiological effects, some of which have been furnished by "the modern pharmaceutical expert" who, according to Mr. Bender, is "at last endeavoring to meet the demand" of homœopathic physicians for strong alcoholic liquids, so that they can pour them over globules without dissolving them. With all due respect to the "modern pharmaceutical expert," he had better devote his energies to something more scientific and worthy of his skill; and to the homœopathic physicians who are so enamored of cane-sugar globules as to have created this "demand," I would gently suggest that they cultivate some pharmaceutical sense.

TINCTURES OR "FLUIDS"—WHICH?

BY JOHN M. WYBORN, F. C. S. (LONDON).

A RECENT writer in the HAHNEMANNIAN MONTHLY (Edward A. Bender, Ph.G., Philadelphia) discredits the "almost superstitious belief in the superior efficacy of the old pharmaceutic products," including, of course, fresh-plant tinctures. "At present," he asserts, "the tendency on the part of leading therapists is towards the use of alkaloids, active principles, rather than continued use of the inexact, often faulty, solutions of the drug."

The "new class of liquid preparations called fluids" are the ideal representatives of the vegetable drug, not the green-drug tinctures; so he would have us infer. These "fluids" are solutions of dried plants in 95 per cent. alcohol, in the proportion of one part of the plant to two parts of alcohol.

Dr. So-and-So "tells" him that a tincture of *digitalis* prepared according to the method of the homœopathic pharmacopœia is utterly unreliable, when given for its physiological effect; and in the case of *gelsemium*, Messrs. So-and-So, themselves manufacturers of a green-drug tincture (and, it may be added, specialists in the preparation of the new fluids), made a careful investigation into the matter, and it was proven to their

satisfaction that a preparation made from the dried drug was not only quite as active, but was more uniform in its strength and results.

Are these statements entirely borne out by the facts? Let us first take a familiar example of a drug universally employed in the dried state, though, as a seed, possessing the vital germ, with its albumin and other ingredients provided for its sustenance unimpaired.

The fluid (liquid) extract of *nux vomica*, prepared as directed in the British Pharmacopœia, 1898, will yield, without the shadow of a doubt, when submitted to chemical action, 1.5 grammes of strychnine from each 100 c.c. of liquid at 15.5° C., showing that 1 gramme is dissolved in, or is obtainable from, 67 c.c.

Now, let us try and redissolve this strychnine in cold alcohol of any strength. We shall find that 67 c.c. are utterly incapable of effecting the solution of 1 gramme, and, according to Squire, its solubility will be 1 in 160 of alcohol, 90 per cent.; about 1 in 400 of alcohol, 60 per cent.; 1 in 300 of absolute alcohol.

Hence it is clear that the strychnine did not exist as such, or uncombined, in the fluid extract. Other substances must have been united with it, to render it soluble to the extent of 1 in 67.

In the case of bitter almond, or the fresh leaves of cherry laurel, similar combinations exist, and it is only by means of heat or chemical action that prussic acid, their supposed active principle, can be separated from them. It would be easy to separate hydrochloric acid by similar chemical means from salt beef, and as well might this acid be declared to contain the virtues of that article of food.

Such being the case, we may fairly infer that the medicinal action of the active principles supposed to represent the properties of the seeds of *nux vomica* and of other trees varies in a corresponding degree, when thus artificially obtained, from that of the natural group from which they are extracted. So much for the alkaloids as representatives of the drugs they are derived from.

It is, however, between fresh living plants and their dead and dried substitutes that the difference becomes most marked.

In the animal organism, the formation of cadaveric alkaloids and poisonous albumose quickly follows death, and it is, therefore, not surprising that similar changes, and the loss of volatile acids and active ingredients, should occur after death and during the drying of the fleshy roots, stems, etc., of plants.

To cite only one instance—that of the genus *Anemone*, including *Pulsatilla*.

Beckurts (*Chem. Centr.*, 1885, 776–778, and *Arch. Pharm.*, 230, 182–206) has shown that several species of anemone owe their acrid taste to the presence of anemone-camphor, which has a powerful irritating odor and a vesicant action.

This readily decomposes during the drying of the plant into anemonin (anemonic anhydride) and isoanemonic acid, the latter being insoluble in water, alcohol and ether. To this decomposition he ascribes the loss of acidity in the plant when kept, and in the pharmaceutical preparations of *pulsatilla*. Other volatile constituents of the plants were obtained which, when recovered from the distillate, took the forms of anemonic and anemoninic acids. The experience of those who have carefully studied and compared the results obtained respectively from the fresh-plant and dried-plant tinctures of *pulsatilla* tallies with these researches of Beckurts; and, were it necessary to multiply instances of the kind, numerous examples are available.

The question for the homœopathic physician must always be, not "What is the most active and definite preparation?" but "What is the best representative of the substance used in the proving which yielded certain groups of symptoms?"

It has been evidently shown that this is not usually the alkaloid, "fluid," or dried-plant tincture, in cases where the fresh living plant or its essence or fresh-plant tincture has been so employed.

CUPRUM ACETICUM IN BLEPHARITIS MARGINALIS.—Dr. Mossa (*Allg. Hom. Zeitung*) has found *cuprum aceticum*, 3d dilution, a most valuable remedy in granular inflammation of the eyelids. Its indications are photophobia, heaviness of the eyelids, sensation of sand in the eyes, and inability to use the eyes under artificial illumination. He has also applied the remedy locally. The cases were mostly in children with scrofulous constitutions.

SOME OBSERVATIONS UPON HYPERCHLORHYDRIA.

BY O. S. HAINES, M.D., PHILADELPHIA.

HYPERCHLORHYDRIA is a rather common condition, sometimes overlooked, frequently disregarded; yet it should not be so, for it is usually a signal, warning the alert and far-sighted physician of more serious mischief yet to appear, if not already present. We prefer to regard hyperchlorhydria as a warning signal of varied import, rather than an affection of the stomach requiring specific medication.

Indeed, many cases of this secretory neurosis, in which there are no recognizable signs of disease to be found in the stomach aside from the hyperacidity, will not prove amenable to the resources of our medicinal therapeutics; will not be permanently influenced by alkalies; will not be more than ameliorated by such remedies as atropine; will not even be cured by the accurately selected similitum.

We suspect the existence of hyperchlorhydria generally from the gradual development of a train of symptoms which, upon their first appearance, may be slight in degree, but which will surely increase in their intensity and become more frequent in their recurrence. We confirm our suspicions by the modern methods of gastric diagnosis. The earliest symptom, in our experience, is pain, or at least discomfort, referred to some part of the epigastrium, and experienced some hours after the ingestion of a meal. This is commonly regarded as a symptom of dyspepsia. It does not yield permanently to those remedies commonly useful in dyspeptic cases. It may be quickly ameliorated, for the time being, by more food, especially if the latter be meat or milk, or by a soda-mint tablet. Patients are quick to make these observations, and they eat frequently, and have generally restricted their dietaries somewhat, before consulting a physician.

Soon, gnawing, and a sensation of burning and pressure, are added to its symptomatology. Occasionally, nausea or vomiting may occur. During the existence of the pain the epigastric region is tender; but the soreness or tenderness is not

localized. We do not find the exquisite point-tenderness supposedly characteristic of gastric ulcer. The presence of a point of special tenderness in the epigastric region, or to either side of that region, calls for especial care in differential diagnosis. The support or gentle pressure of the hand is often agreeable during the attacks. Bodily exertion or exercise, on the other hand, is generally avoided; it seems to augment the suffering. The rapid transition from a state of suffering and distress to one of comparative well-being and comfort, when albuminous food or meat is taken, is often remarkable. The patient, at times, finds himself at a loss for words that will accurately express the weak, gnawing distress which he experiences two or three hours after a meal. "Pain" does not always define his feelings at such times. Exceptionally, this distress does not recur after every meal, but only at certain periods of the twenty-four hours.

We cannot agree with the general statement that loss of flesh does not occur. Not infrequently, in spite of many meals a day of a highly nutritious character, emaciation and loss of strength are quite noticeable. At least such has been our observation, made several times. "The more he eats, the thinner he becomes," has expressed it, in not a few instances. Food is taken rather to assuage the gastric distress, and food so taken does not perfectly nourish the body. Vomiting has been exceptional; more often nausea is succeeded by an acid eructation, or the regurgitation of a mouthful of fluid, followed by vertigo, faintness, and a desire to lie down.

Constipation may be a troublesome feature, but is not universally present. Lowness of the spirits, melancholy, a hypochondriacal frame of mind, are usual accompaniments. The mental anxiety may take the form of a fixed apprehension that serious organic disease of the stomach already exists. The more intelligent the patient, the more scientifically will he elucidate his apprehensions, for the benefit of his physician. The periodical return of the gastric pain and distress at a certain time after each meal is often noteworthy. One of my own patients declared that it recurred two hours, to the minute, after food had been taken, whether he was asleep or awake.

In the absence of food, copious draughts of water, or the swallowing of a considerable amount of saliva, the secretion of

which has been provoked by the chewing of spruce gum, will ameliorate the pain. The slow mastication of a bolus of whole wheat grains, swallowing the saliva produced, is often quickly effective, and in some of our cases has seemed preferable to the immediate taking of more food. Too frequent meals may have a tendency to add other discomforts, although there has seemed to be an almost unlimited capacity to digest in these cases, provided the food chosen was not too starchy in its composition. With such a train of symptoms as our guide, we test for the HCl in the usual manner. Two or three drops of the dimethyl-amido-azo-benzol solution are added to ten c.c. of the filtered gastric contents removed an hour after a morning meal, consisting of a baker's roll and ten ounces of water or unsweetened tea. Then a deci-normal soda solution is allowed to flow, drop by drop, into this from a burette, until a pure yellow color has replaced the red. The number of c.c. of this solution which would neutralize 100 c.c. of such a stomach's contents, multiplied by 0.00365, will give us the percentage of HCl present. Then we may, in addition, ascertain the total acidity of our specimen. A total acidity ranging between 70 and 90, or even higher, considering the normal to be somewhere between 40 and 60, will confirm our diagnosis.

A neurasthenic breakdown is not infrequently, we believe, foreshadowed by the symptoms of a hyperchlorhydria, and their significance in this direction should never be disregarded by the general practitioner under whose observation these cases will likely first come. We have seen cases—a number of them—in which the first pronounced symptoms, indicating that the wear and tear of overwork and worry were tending towards a nervous break, have been the gastric symptoms of a hyperchlorhydria. It is almost useless to attempt to correct these cases by internal medication. The therapeutic indications are for a radical change in the life of the individual. If he has been too studious, he must rest his mind and exercise his muscles. If dissipated, he must be in bed at ten, and give up his stimulants. The hyperchlorhydria in such cases yields quickest and most permanently, in our experience, to a rest in the woods. The patient should take to the woods, where Nature is in her peaceful moods. Rowing is the best of physical exercises, so a convenient lake is a desirable adjunct. With his

days spent in tramping and rowing, long nights in bed, and sound sleep, the diet of such cases need not be too scrupulously watched. Such a plan of treatment cures the hyperchlorhydria of brain-workers threatened with neurasthenia, or suffering from it, better than any drug. Alcoholic stimulants, especially beer and whisky, are distinctly disadvantageous. Whisky sometimes produces a momentary amelioration of pain that is a delusion and a snare to the unwary.

Not a few cases of gastric ulcer are heralded in their incipency by symptoms of hyperchlorhydria. The patient has grown anæmic; or, if a female, has shown signs of a chlorosis, and has had disturbances of her menstrual flow. He or she begins to suffer pain, not immediately after a meal, but at a later period of digestion. Tests reveal increased acidity. Now, if the mode of life of such cases can be re-arranged, homœopathically indicated remedies cure, in this stage. If this stage is neglected by the patient, his or her future will probably be gastric erosion or recurring ulceration.

I have now under observation a man who has suffered from greatly dilated stomach for some two years. Hyperchlorhydria and its train of symptoms was, indeed, the first complaint. It was an occasional condition in the beginning, but gradually became almost constant. His pains, which are severe, and his acid vomiting, are caused by the increased secretion of very acid gastric juice—at least it seems so. There has been nothing so effective in this case as lavage. After three or four washings the acidity diminishes, and a period of comfort follows. I explain the hyperacid secretion in this case by supposing that the lack of motor power permits food to be retained for a long time, and that the latter causes, by irritation, increased secretion of gastric juice. While opposed to the cultivation of “the stomach-tube habit,” we are decidedly in favor of stomach-washing, in selected cases of hyperchlorhydria. At times it seems to provoke a reaction to internal remedies in cases that had hitherto been very obstinate. This is especially true of those cases in which hyperchlorhydria is associated with chronic gastritis, with dilatation, or with motor insufficiency.

Paxson has laid great stress upon the pernicious effect of an over-indulgence in tobacco in these cases. He finds it easier to cure if the habits of smoking and chewing are entirely

given up. Coffee is harmful to some cases in our experience, and its effects must be carefully estimated in all cases, preparatory to treatment. In those cases in which a radical change is impossible, we have obtained good results from cold sponge-baths daily, followed by systematic exercises. The avoidance of "worry" is an essential in the management of all cases, especially those associated with neurasthenia or a neurasthenic tendency. Fletcher's little book upon "Menticulture" is sometimes a capital prescription. We have seen a few cases that were markedly aggravated when the hot season was well on, and inquiry revealed that such cases indulged to excess in cold, acidulated drinks, such as iced-tea flavored with lemon-juice; hence we have thought it advisable to prohibit acidulated beverages. Highly-seasoned foods generally aggravate or perpetuate a hyperchlorhydria.

It is well established, nowadays, that hyperchlorhydria may be an associated condition in many diseases of the stomach, as well as in other affections quite independent of that viscus. The necessity for a careful differential diagnosis in all cases presenting this symptom becomes at once apparent. Bickley has called our attention to the clinical importance of the estimation of the quantity of HCl, as a routine measure, in all diseases of the stomach, previous to beginning their treatment. It is not my privilege to consider the therapeutics of this subject at this time, but Dr. Halbert will easily show that the therapeutic portion of the subject is by far the most interesting, and by far the better understood.

THE VALUE OF OCULAR EXAMINATIONS IN THE DIAGNOSIS OF CERTAIN MANIFESTATIONS OF HEREDITARY SYPHILIS.—Puech believes that to the triad of symptoms—the teeth, the keratitis, and the disturbance of hearing—mentioned in the classic work of Hutchinson, should be added an arthritis that especially affects the knee-joints. Of twenty-seven cases of syphilitic keratitis of hereditary type which have consulted the author during a period of six years' time, eleven had an arthropathy; while disturbance of hearing was present in but five instances. The joint lesions also had a more intimate time-relation with the corneal inflammation. He gives three histories in which the presence of the keratitis rendered the etiological diagnosis certain and the cure of coexisting joint lesions possible.—Puech, Bordeaux, *Archives d' Ophthalmologie*.

EDITORIAL.

SELDEN HAINES TALCOTT, A.M., M.D., PH.D.

BORN JULY 7, 1842, AT ROME, N. Y.

ENTERED INTO REST JUNE 15, 1902, MIDDLETOWN, N. Y.

IN the death of Dr. Talcott the homœopathic profession loses one of its strongest advocates, inasmuch as he was one of the first to fully demonstrate the successful application of Homœopathy in the treatment of the insane.

Nature had endowed him abundantly with her gifts, and he used them wisely, as shown by his record, beginning in the old Academy at Rome, N. Y., and in his service in the 15th Regiment of the New York Volunteer Engineers during the Civil War; in Hamilton College, where he graduated in 1869, and in the New York Homœopathic Medical College and Hospital, from which he graduated in 1872; in his practice in Waterville, N. Y., where he was associated with Dr. E. A. Munger, whose daughter, Sarah A. Munger, he married; and at Ward's Island Homœopathic Hospital, New York City, where he served as Chief of Staff from early in 1875 until April 24, 1877, when he resigned in order to take up his work as Superintendent of the Middletown Asylum, now known as the Middletown State Homœopathic Hospital.

From his entrance into prominent official professional life he has attracted the attention of those who were opposed to him, as well as the admiration of his friends, by his ability, industry and tact, and by the successful manner in which, at all times and in all places, he has shown his unwavering adherence to the principles of old-fashioned Homœopathy. Upon assuming the duties of Medical Superintendent at Middletown, he at once began the work of placing the institution on a sound financial basis, watching all expenditures closely, to see that they did not at any time exceed the income derived by the hospital.

He believed that, as it was a State institution, all classes of taxpayers should be freely received, and that to each and every patient should be given that degree of care and attention individually demanded by his social, physical and mental needs. The good of the patient was to be considered at all times, irrespective of the cost that this needed care and attention might involve. This he demonstrated was practicable, and it is a tribute to his executive genius that the Middletown Hospital won a name that is second to none other of its class in the world.

Untrammelled by previous experience with the insane, at a period in which old-time methods of labor, detention, seclusion and chemical and mechanical restraints were in vogue, his generous and philanthropic mind turned naturally to the study of hospital methods for the care and relief of the insane, with results that hitherto no superintendent in this country had ever attained.

Sympathetic kindness, unceasing watchfulness, homœopathic and consequently humane treatment, became the ruling essentials, and the employment of hospital methods gradually crystallized into the "Hospital Idea," which meant the best care obtainable for the sick insane. To quote the doctor's own words, "We have always endeavored to practice the precepts of the Golden Rule in behalf of our patients. We have given them the benefits of the rest-treatment, which is simply obedience to that injunction of the Healer of Gennesaret, 'Come unto me all ye that labor and are heavy laden, and I will give you rest.' We have always believed that an exhausted physical system must be recuperated and thoroughly nourished before the nervous system can take on that tone and temper which makes it the fit residence of a sane and natural mind."

Conscientious attention and homœopathic treatment, with kindness ever uppermost, soon brought the Middletown Hospital marked approbation from the critical public, and the reports issued yearly by Dr. Talcott have been models in their way—full of interest to the profession and of high literary excellence. As one prominent alienist of the old school said to me, "The reports of the Middletown Hospital are the only ones I save. They are of value, and I frequently refer to them."

Dr. Talcott's work made the Middletown Hospital favorably known throughout Europe, as well as this country, one of the best reviews of the year's work done in Middletown coming from Belgium. When he first went to Middletown there were about one hundred patients; now there are nearly thirteen hundred; and the admissions during the hospital's life aggregate six thousand and over.

Just one month ago, on the evening of the dinner given to Dr. Talcott, commemorating his twenty-fifth anniversary at Middletown, Dr. William Tod Helmuth, who had prepared a poem for the occasion, and who was to have been the last speaker, passed away at his home just as the banquet closed. We give the verses here, as read by Dr. George W. Robertson that evening:

"Look at my hair, and see it silver gray;
Look at my eyes, behold the dangling glasses;
Look at my ears; you know full well that they
Are not acute to every sound that passes.

"You knew me when these same old locks were brown,
With ears responsive and eyes quick to see;
I recollect when you came up to town
With letters introductory to me.

"A stripling, then, from dear old Munger's care,
Burning with the Æsculapian flame,
With slender body and with flowing hair,
Up to your Alma Mater's courts you came.

"Do you remember then that I was teaching
The new suspension for a fractured thigh?
The old straight splint of Physic was impeaching
When you besought me Munger's splint to try.

"Take down the worn old volume from the shelves,
Turn you to page five hundred ninety-five;
Ah! mem'ry then will tell us of ourselves,
Both you and I—Thank God we are alive.

"As retrospection stealeth o'er the years
To touch the men who lectured then to you,
Our hearts grow sad—our eyes o'erflow with tears,
So many gone—the remnant still so few.

"But I must play you Ganymede to-night,
And give this cup, all filled with ruby wine,
In friendship's name from those who, with delight,
Have watched your progress since you fell in line.

“Take it, old man, with all the love it offers ;
Take it and keep it, for it tells a story ;
Take it—’tis better than o’erflowing coffers ;
Take it, resplendent with true friendship’s glory.”

What the profession has lost, what the public has lost, and what his wife has lost is beyond ordinary expression. Our sympathy goes out to them.

Ever helpful to others, he received recognition from his college, it having conferred upon him the degree of A.M. in 1872 and Ph.D. in 1882. He has been President of National, State and County Homœopathic Organizations. As a public speaker he had few equals, as a writer he was one of the best in our school. He has contributed only one volume to our medical literature, that on “Mental Diseases and Their Modern Treatment;” but he has written freely upon subjects connected with his work, and these articles have been printed in many of our journals and society transactions.

As Professor of Mental Diseases, many old students of Hahnemann, and, later, those of the New York Homœopathic Medical College and Hospital, will remember their versatile teacher with pleasure. That kindness, sympathy and helpfulness he so willingly gave out to others will be remembered by thousands who came within the radius of his forceful personality. As Secretary Hay said of McKinley, so can we of Talcott :

“History is inexorable. She takes no account of sentiment and intention ; and in her cold and luminous eyes that side is right which fights in harmony with the stars in their courses. The men are right through whose efforts and struggles the world is helped onward, and humanity moves to a higher level and a brighter day.”

C. SPENCER KINNEY.

SUMMER DIARRHŒAS OF CHILDREN.

ALTHOUGH it is true that diarrhœa is only a symptom, not a disease, yet in the majority of cases its characteristics furnish the clearest and most reliable indications for the treatment of the pathological condition of which it is the index. In all our work the claims of science for a recognition of underlying pathological conditions in any case dare not be disregarded,

and yet a cure without this is to be preferred to a fatal result with it. Better by far a doubtful diagnosis in a living patient than a confirmed diagnosis in a dead one. Fortunately, in the class of cases of which we wish to speak there is but little doubt as to the general pathological condition, and the only element of uncertainty is in regard to their exact location and the extent to which they have progressed. "The pathological relation existing between the different forms of diarrhœal diseases is a very close one. The same case may pass successively through the stages of acute indigestion, gastro-enteric infection and ileo-colitis. This transition may be slow, or it may be so rapid that the different stages cannot be distinguished. Instead of passing through the entire series, the process may stop at any stage and the case recover, or at any stage it may prove fatal." (Holt.)

In the simplest form of diarrhœa there is only, if anything, a congestion of the mucous membrane, which, according to the duration of the disease and its extension, may pass on to a catarrhal or even croupous or diphtheritic inflammation, with areas of ulceration. The presence and virulence of certain as yet unisolated micro-organisms may at once give rise to the symptoms of true cholera infantum, or the gradual development of their activity may cause an entero-colitis to assume a choleraic type.

Before proceeding to consider the summer diarrhœas of children, it will be necessary to glance at two forms of functional derangement of the intestines which, in a very great number of cases, are the beginnings from which the more serious organic lesions take their origin.

We have the nervous and dyspeptic types of simple functional diarrhœa. In certain infants and children, in whom the normally unstable character of the nervous system is exaggerated, heat, cold, emotions, or the presence of foreign bodies, food or otherwise, are sufficient to produce a form of looseness of the bowels, unaccompanied by any appreciable change in the mucous membrane of the small or large intestine, either of which may be the seat of the reflex irritation.

The more frequent form of functional diarrhœa met with is that resulting from indigestion, usually in the intestines; for it is there that the principal work of digestion is carried on

during infancy and early childhood. Here the food is at fault, either as regards quantity or quality. Both breast-fed and bottle-fed infants suffer, the former to a less extent, however, than the latter, as can readily be supposed.

A predisposition to these functional diarrhœas is furnished by summer weather, delicate constitution, previous attacks of indigestion, and age. In the nervous form the attack is liable to be sudden. There is some, but not excessive, abdominal pain and restlessness. After two or three rather liquid discharges of a yellowish-brown color, the stools become more watery, and frequently of a lighter color, but seldom green, and not offensive. Vomiting is not a striking feature of the attack. Colicky pains, flatulence and stools indicative of indigestion are more marked in the dyspeptic form. Undigested food is found as large white curds of casein, or as smaller, yellowish-white flakes of fat, in the case of a milk diet. The color of the stools changes to green from the formation of biliverdin, their reaction becomes acid, and their odor is sour or foul. In sudden attacks the temperature may reach 102° to 105° in infants, 100° to 103° in older children, but in twenty-four hours it falls nearly, if not quite, to the normal. In cases of gradual onset the temperature seldom reaches 101°. The general prostration is greater in infants, and in cases beginning abruptly may threaten life.

The prognosis depends upon the previous condition of the patient, the nature of the exciting cause and possibility of removing it, and the opportunity of carrying out proper treatment. In delicate children a serious attack of acute intestinal indigestion may lead the way to severe organic changes in the intestines.

To those forms of deranged function of the intestines which are accompanied by structural changes we reckon the *Summer Diarrhœa of Children*, or *Acute Gastro-enteritis*, or *Enterocolitis*, and *Cholera Infantum*. These changes are found especially in the lower ileum and the colon. The swelling and softening of the mucous membrane is sometimes so great in this location as almost to occlude the valve, to which has been attributed the vomiting which often occurs with an absence of gastric lesions.

The general influences predisposing to this form of disorder

are age (under two years), feeble constitution, unhygienic surroundings, malnutrition from improper food; while long-continued excessive heat has been found, by universally concurrent statistics, to be the main exciting cause. The action of the heat is now no longer regarded as direct, but as indirect. The view generally held at present is that summer diarrhœa is of infectious origin, and that the heat contributes to the occurrence of acute indigestion, resulting in the retention of decomposing food in the stomach and intestines, whereby conditions favorable for the development of various bacteria are furnished. Some of the micro-organisms found in connection with these diarrhœas, *e.g.*, the bacillus coli communis, are, under normal conditions, not pathogenetic, but, under abnormal conditions, *e.g.*, such furnished by improper feeding, become pathogenic, owing to an irritating substance in their protoplasm. (Pfeiffer, Loeffler, *et al.*)

Only isolated cases occur during the winter months, and these among the poor, where the infants are exposed to sudden changes of temperature, and are compelled to breathe an impure atmosphere. According to the character of the season, about the middle of May or June, cases become more numerous; and when the long-continued heated term is established in July and August, the disease assumes an epidemic character, lasting, with variations depending upon the temperature, into September or October, August being the most fatal month.

Infants between the ages of six and eighteen months are the most numerous victims, owing to the sympathetic irritation depending upon the eruption of the teeth and the rapid development of the intestinal glands and follicles, together with the changes in diet usually inaugurated at that time. From the eighteenth month to the end of the second year only about one-quarter as many cases occur, while the fewest are met with under six months.

The occurrence of the vast majority of cases in the large cities, among the poor, living on improper food in overcrowded and filthy surroundings, in an atmosphere polluted by poisonous gases and containing countless bacteria, while in the open country, with the same temperature prevailing, its occurrence is exceptional, shows that all these circumstances are essential factors in its causation.

The condition usually begins with the symptoms of intestinal indigestion, and hence we see how important it becomes to recognize these, and to combat them at once. Neglect to appreciate the connection existing between the various forms of intestinal disorder, as above indicated, has been the cause of the occurrence of many a fatal entero-colitis which might have been avoided.

It will not be in place here to enumerate the various symptoms of the summer diarrhœas of children, but we would wish to draw attention to a mistake which is, we believe, frequently made, and that is calling every case of "summer complaint" cholera infantum. The term "cholera infantum" should be exclusively restricted to the class of cases marked by intense choleriform symptoms. The symptoms characteristic of this disorder are rapid onset; constant vomiting; frequent serous discharges; intense thirst; high rectal temperature, low surface temperature; collapse; depressed fontanelle; sudden loss of weight, and distressed, restless expression, suggesting speedy death—all developing in from twenty-four to forty-eight hours. (Rotch.)

As will be recognized, several of these symptoms are often simulated in severe cases of entero-colitis; but the suddenness of onset and the rapidity of development serve to mark the case of cholera infantum, together with the serous alkaline nature of the discharges.

These characteristic features point to serious nerve-involvement, probably of the sympathetic, due in part to the irritating toxins which had developed either in the food before administration or in the intestinal tract, and in part to the nerve-exhaustion produced by excessive heat. The specific micro-organism concerned has not yet been isolated, but that it is normally pathogenic, we think, can be seen from the fact that it can produce its characteristic effects in a perfectly healthy child, as well as in one who has been suffering from an attack of indigestion or of entero-colitis.

The prognosis of a case of cholera infantum is always grave; hence our duty is to be most exact in diagnosing it, and in reporting the result of treatment.

Looking at the various forms of diarrhœas which are likely to present themselves at this season as closely correlated, in-

deed as possible successive stages in the same pathological process, we are enabled to summarize the methods to be applied in their treatment.

Much can be done in the way of prophylaxis, by the closest attention to diet and to general hygiene. Pure water, pure air, and pure food, with attention to regular habits of feeding and cleanliness, are ideals to be striven after, not only as means for preventing the development of intestinal trouble, but also as requisites for treating them successfully.

Regulating the diet during an attack is of the utmost importance, and the stopping of milk is a cardinal point. Water (boiled) hot or cold, white wine whey, weak broths, egg-water, barley-, wheat-, or oatmeal-water, can be substituted, in small quantities, at frequent intervals. Washing out the stomach, where vomiting is an early and prominent symptom, may in some exceptional cases be called for. Of greater utility, and less objectionable to the patient, are injections of water at 97° or 98°, pure or variously medicated where the temperature is high and the abdomen distended, with small mucous stools. The object of both these procedures being to remove toxic material, the result of proteid decomposition, and thus to destroy the culture-medium for the development of bacteria introduced from without, they need only be resorted to where nature's efforts, aided by our medicines, show themselves incapable of producing results. They belong too much to the mechanical treatment of disease, so much in vogue at the present time, to recommend themselves to us as routine treatment.

The use of *Merc. dulc.*, one-tenth of a grain, repeated every hour until from five to ten doses have been given, will answer the same purpose, although it may seem just as objectionable to some. In cases of cholera infantum, the high temperature may be combated by baths beginning at 100°, gradually lowered to 80°-85°, or the collapse met by keeping the child warm by artificial means and warm drinks, even if vomited. Small doses, frequently repeated, of hot coffee, will often prove very effectual.

To counteract the results of the great loss of fluids, in all cases water should be given freely, either by the mouth or by the injection of the decinormal saline solution.

Stimulants, of which brandy is the best, are often necessary.

As to remedies to be used, homœopathy offers a richness which is often embarrassing, and we will do no more than draw attention to several which, in our experience, have stood out prominently as most frequently serviceable.

In dyspeptic diarrhœa, *Bell.*, *Nux vom.*, *China*, *Nux moschata* and *Podoph.*,—the latter on the confirmed characteristics of changeable color of the stools and their great profuseness.

In entero-colitis, one remedy "which works like a charm" is *Ænothera bien. o.*, followed closely by *Arsen.* and *Merc. sol.*

In ileo-colitis, besides *Merc. cor.*, *Kali mur.* In this form of intestinal trouble we have found that the remedies given dry have cured, while they had only aggravated the case when given in water.

In cholera infantum, in addition to the well-known *Camph. ars.* and *Verat. alb.*, *Cuprum ars.* and *Sulphocarbonate of zinc* have seemed at times to prevent the but too frequent fatal terminations.

The *genius epidermicus* plays in these disorders a most prominent rôle, and the observant physician will often be led to the *successful* use of a remedy or remedies in nearly all cases, even when apparently not indicated. While one treatment should not with malice prepense exclude any means or adjuvant known to the profession at large, it should not, of necessity, include any or all of them to the neglect of those remedies which have proved their efficacy in this practice of thousands of homœopathic physicians.

W. H. BIGLER.

TREATMENT OF STRICTURE OF THE LACHRYMAL DUCT BY ELECTROLYSIS. —Silver was found to be the best metal to use, and he preferred to place the positive electrode on the wrist. As a stricture was near the whole length of the cause, it was a matter of much importance to apply the current only to the narrowed portion. He had used the volt selector, the amperemeter and a rheostat, with the Edison 110-volt current.

Any one could satisfy himself of the relaxing effect of the current by introducing an instrument which is tightly grasped, and then noting how loosely it was held after the passage of the current. Each seance should last from thirty seconds to three minutes. The author claimed that electrolysis is harmless if used properly, that it is antiseptic in its action, that it is much less painful than the usual mode of passing probes, and that it dissolves and relaxes stricture much better than any other method, thus diminishing the danger of tearing the mucous membrane and making false passages.—Dr. L. L. Mial, New York, *Jour. Oph., Otol. and Lary.*

GLEANINGS.

THE PROGNOSIS OF PLEURISY WITH SEROUS EFFUSION.—Cabot (Boston) has undertaken to study the outcome of cases of pleurisy with effusion, in which there was no evidence of tuberculosis. He has followed up, by letter or by personal visit, 152 such cases, and the result of his statistical analysis permits the following conclusions:

1. Eighty per cent. of the patients, having uncomplicated serous pleurisy, who have been followed for five years or more, are in good health.

2. Ninety per cent. are apparently in full health at the end of from two to five years; that is, the pleurisy has no immediate connection with any other affection.

3. Fifteen per cent. of the patients sooner or later developed demonstrable tuberculosis of lung or bone. But in only 3 per cent. has this tuberculosis manifested itself within two years of the pleural effusion.

4. The type of tuberculosis which occurred in these cases was, as a rule, mild, and of slow course. Death did not occur until five years or more after the pleurisy in one-half of the 23 patients who developed obvious tuberculosis. Six of the 23 are still alive, despite the tuberculosis, after periods of 1, 2, 4, 9 and 10 years.

5. Nevertheless, a very rapid form of tuberculosis may develop many years after the pleurisy—9 years and 16 years, respectively, in 2 cases of this series—so that the patient is never safe from the possibility of death from tuberculosis merely because the pleurisy lies 10 or 15 years behind him.

6. A study of the clinical records of the whole group of patients under consideration shows that, among those who have remained in perfect health for five years or more, only 25 per cent. had any family history or past history of tuberculosis, while of those who became tuberculous, two-thirds had tuberculosis in their immediate family, or in their own past history. A careful history, therefore, is of great importance in the prognosis of pleural effusion. On the other hand, the physical signs during the course and convalescence of the pleurisy were not markedly different in the group of cases in which tuberculosis later developed from the signs in those who have remained well.

7. Recurrence of the pleurisy itself, in patients who have recovered from the original attack, occurred in only 5 cases, or 3 per cent. of the series. Reaccumulation of the fluid after tapping is rare, occurring in only 2 cases, or 1.3 per cent.

8. Among the 14 patients who, after recovery from the pleurisy, died of some other disease, not one developed any disease which could reasonably be considered a result of the pleurisy. The causes of death were: alcoholism, hepatic cancer, dysentery, pulmonary embolism, mitral stenosis, aortic regurgitation, chronic nephritis (3), cerebral hæmorrhage, measles, pneumonia (3).

9. Finally, the author calls attention to the fact that he has made no attempt to discover what percentage of the whole group of cases is due to tuberculosis. So far as his statistics go, the cases may be all of tuberculous origin. What his figures do prove is that, whether pleurisy means tuberculosis or not, the outlook is bright, provided no family history of tuberculosis clouds it. If pleurisy means tuberculosis, it is a very mild form of tuberculosis, and one from which recovery is usually complete, under proper treatment. Even if the lungs are attacked later, the type of the disease is unusually mild.

The author, in this research, found that the patients most difficult to trace were those who are still alive and in good health. This, he thinks, tends to explain the dark views often held of the outcome of pleurisy.—*American Medicine*, June 7, 1902.

F. Mortimer Lawrence, M.D.

BLOOD POVERTY AS A CAUSE OF GASTRIC ULCER.—In a paper read before the section on Practice of Medicine of the American Medical Association, Robert N. Willson (Philadelphia) reached the following conclusions :

1. In many, perhaps in most, cases, a high grade of anæmia precedes the appearance of the peptic ulcer, and this anæmia usually assumes the chlorotic form.

2. With few exceptions, gastric ulcer is attended by the symptoms of marked anæmia. In certain cases in which the blood picture fails to show a reduction in the hæmoglobin percentage and in the number of red cells, the fact seems to be due to the concentration of the blood dependent upon anæmic causes.

3. General anæmia means anæmia also of the pylorus, and consequent inanition of its mucous membrane.

4. The venous outlet from the pylorus is one that, in anæmic subjects, would predispose still further to an unhealthy condition of the muscular and membranous coats of the pyloric wall.

5. Hypertrophy is usually present in chlorosis and often in other forms of anæmia, and when present in any condition, it is an influence predisposing to gastric ulcer, when associated with an anæmic gastric wall.

6. Hyperacidity is not essential to self-digestion of the stomach-wall, provided that the wall lacks proper nourishment and stimulation from a healthy or sufficient blood-supply.

7. Any form of hæmorrhage, menstrual, operative or anæmic, may either predispose to, or accentuate, an already present anæmic condition of the gastric wall, and such hæmorrhages are *de facto* often followed by gastric ulcer.

8. The foregoing facts, in association with the general one that gastric ulcers are seen almost invariably in anæmic subjects, warrant the conclusion that blood poverty is a leading and the usual predisposing cause of peptic ulcers.—*American Medicine*, June 14, 1902.

F. Mortimer Lawrence, M.D.

AN ANALYSIS OF 71 CASES OF TYPHOID FEVER.—(Hano and Walker.)—After admission the patients presented the ordinary symptoms of typhoid in the following frequency : Widal reaction—the percentage giving it was 87.5 per cent. Enlargement of spleen was present in 59 cases, or 83 per cent. It

was usually easily recognized, the nose of the organ being felt just under, or more frequently below, the costal border. In some cases diagnosis of the enlargement rested on the increase of splenic dullness, while in a few it was necessary to rely on tenderness. Spots were observed out of 65 white children in 80 per cent. of the cases. The spots were typical, but not profuse. Constipation was present in 42 per cent. of cases, a slightly greater number than those with diarrhoea. Delirium was sufficiently marked in 11 cases to be worthy of note, the male sex showing a preponderance more marked in the violence than in the number. Intestinal hæmorrhage occurred in four cases, but the amount of blood was so slight as to be scarcely enough to be called a complication. Nose bleed was observed in 3 cases. The diazo-reaction was negative in 16 cases, and in 1 was positive, although this case gave negative results in three attempts at Widal. As an illustration of the value of this test, in one case admitted as pneumonia, with involvement of the right apex and pneumococci in the sputum, a positive reaction on the eighth day was the first indication of a typhoid infection, which ran a typical course. Complications occurred in 18 per cent. These consisted of otitis media, corneal adenitis, vaginitis, nephritis. A prolonged cystitis existed in one case during convalescence, and the urine, collected as aseptical as possible, contained many bacteria; a culture on agar gave a growth of a bacillus which was actively motile; a hanging drop agglutination and cessation of motion were observed on the addition of a blood serum known to give the specific typhoid reaction. Relapses were seen in 6 patients, starting on the seventeenth, twenty-second, twenty-ninth, thirty-fourth and forty-first days, respectively. Mortality percentage was 4.2. As to the use of hydro-therapy in the treatment of these cases, this was started as a tub-bath, the temperature of the water being 85°. A cloth, wrung out of ice-water, was put on the child's head, and the body immersed in the bath. The duration was from five to ten minutes. In a few cases, especially in the younger children, the tub-baths were not well borne, and sponging was substituted.

In conclusion, the author states that while typhoid fever may sometimes run a very mild or even abortive form in children, yet its clinical picture does not differ from that in adults in any essential features save in somewhat lower mortality.—*The American Journal of the Medical Sciences*, June, 1902.

William F. Baker, A.M., M.D.

A STUDY OF THE PHARYNGEAL LYMPHOID TISSUE (ADENOIDS) WITH ESPECIAL REFERENCE TO PRIMARY TUBERCULOSIS OF THE PHARYNGEAL TONSIL.—(Lartigan and Nicoll).—In a series of 200 specimens investigated by Lewin, evidence of tuberculosis was found in 10. This observer reached the following conclusions:

1. Five per cent. of the hyperplastic pharyngeal tonsils contain tuberculous lesions.
2. The lesion resembles the so-called tumor of tuberculosis of the mucous membranes. It is characterized by the absence of all recognizable internal signs—"latent" tuberculosis of the tonsils.
3. This latent tuberculosis may apparently be the first and only lesion of tuberculosis in the body.
4. It is usually associated with more extensive tuberculosis of the other organs, especially of the lungs, although this at the time of operation is not apparent.

5. Tuberculosis of the pharyngeal tonsil is relatively frequent in pulmonary tuberculosis.

6. The tuberculous process may affect normal tonsils. It is doubtful whether the toxins induce the hyperplasia. The tuberculous process may delay the involution of the hyperplastic tonsil.

7. The tubercle bacillus plays little part in the etiology of pharyngeal tonsil hyperplasia.

8. The tuberculous lesion may be entirely removed by extirpation of the tonsil.

The conclusions reached by the writers, after a general review, are :

1. Adenoids consist essentially of hyperplastic pharyngeal lymphoid tissue. The epithelium and fibrous tissues are inconstant and variable, and independent of the age of the patient. The new-formed fibrous tissue is largely perivascular in distribution. It may occasionally be one of the factors in the process of disappearance of the adenoid.

2. The hyperplastic pharyngeal tonsil often contains micro-organisms, and these are mainly pyococcal forms. The bacteria for the most part lie near the surface, and the infections usually occur from the surface, with or without demonstrable lesion of the epithelium.

3. Primary tuberculosis of adenoids is probably more common than most previous studies show. Sixteen per cent. contained tubercle bacilli, 10 per cent. with characteristic lesions of tuberculosis. The tubercle bacilli were present in small numbers.

4. The lesions in primary tuberculosis of the adenoids are generally close to the epithelial surface, and focal in character. Occasionally they may be found in deeper parts of the pharyngeal lymphoid tissue.

5. The pharyngeal tonsil may be a portal of entry for the tubercle bacillus and other micro-organisms in localized or general infections.—*The American Journal of the Medical Sciences*, June, 1902.

William F. Baker, A.M., M.D.

TETANUS AND VACCINATION.—(MacFarland.)—The article is an analytical study of 95 cases. From the consideration of the above case he deduces the following conclusions :

1. Tetanus is not a frequent complication of vaccination, a total of 95 cases having been collected.

2. The number of cases observed in 1901 was out of all proportions to what have been observed heretofore.

3. The cases are chiefly American, and occur scattered throughout the eastern United States and Canada.

4. They have nothing to do with atmospheric, telluric or seasonal conditions.

5. They occur in small numbers after the use of various viruses.

6. An overwhelming proportion occurs after the use of a certain virus.

7. The tetanus organism may be present in the virus in small numbers, being derived from the manure and the hay.

8. Occasionally, through an accident or carelessness, the number of bacilli becomes greater than usual.

9. The future avoidance of the complication is to be sought for in greater care in the preparation of the vaccine virus. The following note is appended :

A complete list of the cases, with the particulars from which the above conclusions are drawn, is in my possession, though the fact that much of its most important information was given me in confidence prohibits its publication. To any one interested in any of the cases I will be glad to furnish all that I know.—*Medicine*, June, 1902.

William F. Baker, A.M., M.D.

THE PREVENTION OF CONCEPTION.—(Kolischer.)—The prevention of conception has not only been a sociological one, but it is fast becoming of interest to medical men. The operative measures for sterilizing women are not considered, but the article refers to the many mechanical devices and arrangements for the prevention of conception. The ones used by the women are of more interest to the medical man than those used by men. The fact that these devices may be dangerous to both parties gives the subject a general medical interest. After reviewing some few cases, he sums up as follows: "The use of soft-rubber caps as preventative pessaries is always a dangerous measure. The practice of leaving it in the vagina during the interval between menstruations is to be condemned. If they are used at all, they must be removed at short intervals and subjected to effective antiseptic douches. These rubber caps may produce inflammatory catarrhs in the pelvic organs that have never been attacked by a specific infection. The secretion of such inflammation may cause a non-specific urethritis in the male. These pessaries are especially dangerous in cases in which the tissues are weakened and made susceptible for new infection by a previous gonorrhœa, and they are apt to increase the virulence of latent gonorrhœa."—*Medicine*, July, 1902.

William F. Baker, A.M., M.D.

SARCOMA OF THE MESENTERY.—Bernays (St. Louis), reports the case of a man, thirty years of age, who gave the following history: Subject to gastric disturbances all his life. For four months has had severe headache, frontal and occipital, with pain in belly, of a bearing-down type in region of umbilicus. Appetite has been good, but for the past two weeks the eating of a very small amount of food has caused excruciating pain, which would cease after vomiting. Has had one or two stools daily, of firm consistence. He has dropped in weight from 165 to 117 pounds. There is nothing of note in former personal or family histories. Physical examination showed a flat, round tumor, the size of a saucer, in the abdomen, freely movable in all directions around the umbilicus, only limited by a band or adhesions on its under surface. A diagnosis of omental or mesenteric tumor was made, and operation advised.

Chloroform was the anæsthetic. A median incision from just above the umbilicus to the symphysis showed a thin myxædematous omentum covering the tumor, which was in the mesentery, and not adherent at any point. It was apparent at once that to remove the tumor alone would mean gangrene of all the intestines attached to its periphery, because all the blood-vessels and lymphatics running to and from the intestines passed through the mass of the tumor. The superior mesenteric artery entered the tumor at its upper edge; its main branches were tied and cut, and the tumor, with the attached intestines, was extirpated. The wound in the mesentery was stiched with a continuous suture, and an end-to-end anastomosis done by means of ordinary interrupted stitches with the knots on the inside. The abdominal cavity was

filled with warm saline solution, and the incision closed by numerous through and through interrupted sutures. The patient made a rapid recovery, free from febrile or suppurative disturbances of any kind. The diet consisted mostly of milk and soup and a preparation of meat juice.

The tumor proved to be a small, round-celled sarcoma. The amount of the small intestines removed involved all of the ileum except three or four inches attached to the ileo-cæcal valve, and a part of the jejunum, the whole length removed being 119 inches. The patient left the hospital on the twenty-third day. He gained steadily in weight and enjoyed good health, with the exception of occasional attacks of severe headache and vomiting, which would pass away upon the regulation of the diet and the administration of a saline purgative.

The author appends a table of thirty-six cases of resection of the small intestines collected from surgical literature. The length of intestine removed ranges from thirty-two inches to twelve feet two inches, practically the whole (death in twenty-two hours). Of these cases death occurred quickly in ten cases; four survived four months; twenty-two cases recovered permanently, and in two of these the colon was partially removed. Senn concludes that one-third the length of the small intestine is about the degree of tolerance in dogs, and resection of more than one-third will be followed by marasmus, which will eventually prove fatal. Trzebitzky finds that in the small animals resections of one-half of the small intestines were quite well tolerated, and that resections of the jejunum were more serious than resections of the ileum. He declares that resections of one-half of the small intestine in man will be quite permissible, provided that it is the distal half. Monari believes that he has proven by his experiments on dogs that seven-eighths of the intestine can be removed without the production of important interference with metabolism and nutrition.—*Annals of Surgery*, June, 1902.

Gustave A. Van Lennep, M.D.

RADICAL CURE OF INGUINAL HERNIA.—O'Connor (Buenos Ayres) reports his experience in over 350 operations for hernia. Of these, 140 were performed by Halsted's method, 120 by Kocher's, and 90 by Bassini's and other methods. The author has abandoned Halsted's method, owing to too frequent supervention of orchitis, with consequent atrophy of the testis; also because he objects to transplantation of the cord from its normal conduit. The same objection applies to Bassini's method. Kocher's operation has yielded as good results as the others, with about 6 per cent. of recurrences, with decidedly less orchitis, and with the patient no worse off than before, if recurrence does take place. The author believes that, no matter what method is followed, the keystone to any radical cure is the approximation of the conjoined tendon to the lower shelf of Peupart's ligament. By the term "lower shelf" he means "Gimbernat's ligament." He describes the following method as having given satisfactory results in 20 cases:

A four-inch incision is made over the line of the inguinal canal, the sac isolated, opened and palpated well into the abdominal cavity. Next, an assistant draws the sac forcibly downwards, and, with a protecting finger within, it is transfixed and ligated with catgut and removed. The conjoined tendon and Gimbernat's ligament are next thoroughly differentiated, and, with a finger introduced into the canal to act as a guide, four strong fishing-gut

(*silk-worm-gut*?) sutures are inserted by a curved hernia needle, half an inch apart, from within outwards through Gimbernat's ligament and the external oblique, the ends being retained outside the aponeurosis. The free ends are threaded in rotation on a hernia needle with an opposite curve, and are carried from within outwards well into and through the substance of the conjoined tendon, these ends being similarly retained outside the sheath of the tendon. A straight aneurysm needle is next made to enter the suture hole in the tendon, passed across, and made to emerge through the corresponding suture hole in the external oblique. The end of this portion of suture is attached and drawn through the aperture of entry of the needle; thus the two ends emerge from the same hole in the sheath of the tendon and form a circular, sub-muscular suture. The cord is then drawn downwards, and the sutures are tied with sufficient force to draw the tendon backwards in front of the vas to Gimbernat's ligament. The ends of the stitches are cut off and the knots allowed to retract into the substance of the conjoined tendon, and are sealed over by a catgut suture through each aperture. The operation occupies usually from 10 to 15 minutes. The skin wound is closed with a continuous blanket suture.—*The Lancet*, May 31, 1902.

Gustave A. Van Lennep, M.D.

RADICAL CURE OF HÆMORRHOIDS WITHOUT THE USE OF GENERAL ANÆSTHESIA.—Davis (Phila.), in a paper read before the Philadelphia Academy of Surgery, presents the following method of treating hæmorrhoids: They are exposed to view by means of a speculum. The author prefers that instrument known as Kelly's sphincterscope; it has a long, firm handle, and after being introduced the patient can hold it in place. A pledget of cotton an inch or more in length is moistened with a 4 per cent. solution of cocaine and introduced, being allowed to remain as the speculum is withdrawn. In a few minutes the speculum is again introduced, the cotton removed, and the hæmorrhoid on which it is desired to operate brought well into view by turning the instrument from side to side. With a small electro-cautery knife, such as is used in nasal operations, the hæmorrhoid is either seared superficially, or a line burnt in it, or one or more punctures made, as deemed most suitable. The skin should not be encroached upon, nor should the application be made too high up, as otherwise the sphincter may fail to compress the bleeding point, and bleeding into and distention of the rectum result. If bleeding is too free, the operation may be suspended and a piece of cotton pressed on the bleeding point and allowed to remain as the speculum is withdrawn. The cotton does not produce any discomfort, and is passed out at the next movement of the bowels.

The operation had better be done late in the day, so that the patient may return to his home, lie down, and by next morning any irritation which may have been produced will have subsided. In a week's time another application may be attempted, and by persistently working in this manner the hæmorrhoids can gradually be removed. The method will be found quite satisfactory in a certain class of cases; but where the hæmorrhoids are very large, this manner of treatment would be too tedious, and consume too much time.—*Annals of Surgery*, June, 1902.

Gustave A. Van Lennep, M.D.

THE USE OF ELECTROMAGNETS IN OPHTHALMOLOGY.—A blacksmith complained of having been injured in the left eye by a piece of steel. A small air-bubble was found in the superior part of the anterior chamber and a small incised wound on the lower lid. With the loupe, a small wound, already healed, was found in the inferior border of the cornea, corresponding with that in the lid. Also a somewhat dark-colored spot at the root of the iris, concealed behind the scleral part of the limbus. No injury of the iris or ileus could be detected, nor any change in the fundus. The circular-shaped pupil reacted normally, and was of the same size as that of the right eye. Vision normal. The anterior chamber was of normal depth and contained no blood. A provisional diagnosis of corpus alienum intra-oculare was made. Extraction with the Hirschberg magnet was unsuccessful, even though the point had been introduced into the anterior chamber through a small wound in the cornea. A month after the injury vision continued to be normal and the eye was quiet. Two months after the injury the foreign body appeared as a glittering sliver of steel on the choroid. Two weeks latter a glittering, yellow-gray, lance-shaped spot appeared under the equator. Patient refused another attempt at extraction with the magnet. Four months after the injury enucleation was performed. A sliver of steel, 4 mm. long and 1 mm. wide, was found in the sclera at a distance of 1 cm. from the disc under the macula lutea. He compares the relative value of the Hirschberg and the Haab magnets, and particularly the small effect at a distance of the Hirschberg magnet, so that the foreign body must be touched if it is to be extracted.—Prof. Kosker, *Annals Ophthal.*

William Spencer, M.D.

THE TREATMENT OF XANTHOMA OF THE EYELIDS.—In cases of superficially located patches, the writer says excision is efficient; but if practiced on large or deep-seated spots it is liable to be followed by a scar, or even ectropion. It is also difficult to remove all the tissue at once.

Electrolysis, he says, is free from the disadvantages which attend the use of the Paquelin galvano-cautery and caustics. It attacks the deposits of degenerated tissue, and its action is strictly local, and at all times under perfect control. There is but little pain. To reach the xanthoma deposits it is necessary to introduce the needle horizontally with the skin. The current should be very weak at first, and gradually increased. A current of 2-3 milliamperes is sufficient, but must be continued for about thirty seconds.

It is hardly possible to remove the larger spots at one sitting, but two or three are usually sufficient. No dressing, except a little dusting-powder, is required. A firm scab forms as early as the second day, and in some cases takes some time to drop off.—Fredk. J. Levisend, *Med. Record.*

William Spencer, M.D.

THE IODIDE OF POTASSIUM IN GALL-STONE COLIC.—Dr. ——— recommends the iodide of potassium in small doses in the treatment of gall-stone colic. He advises a solution of 4 to 6 gms. in 200 gms. of water, one or two tablespoonfuls a day. He has employed this treatment for five years and in thirty cases. As a special indication, he would use it in those cases where, after a short attack of the colic of short duration, the right hypochondrium remains very sensitive and the seat of dull pains. He has succeeded in restoring such cases to health without any other remedies or narcotics.—

Hospitalstidende, No. 5, 1902. (A few years ago a French professor very warmly recommended, in recurrent cases of cholelithiasis, to give three times a day from 5 to 15 grains each of the salicylate and the benzoate of soda, with 5 to 15 drops of Harlem oil twice a week. He asserted that he has cured a great number of cases by this method, and first and foremost cites one of a man of forty-five years, who, after his physician had exhausted his armamentarium, had sent him to Paris to be operated on. He was put on this treatment, and never had an attack since. Of course, he was not operated on. This is not homœopathy, yet these cases give one so much trouble that light from any source is welcome. I have tried the mentioned treatment in a few cases, and obtained good results.)

Frank H. Pritchard, M.D.

THE TREATMENT OF DYSPNOEA.—Lewis (Burlington, Vt.) states that the remedies serviceable for relieving dyspnoea depend entirely on the cause. When the condition is due to the obstruction presented by excessive or tenacious secretions, ammonium chloride is one of the most useful drugs. It may be administered in vapor by bringing the fumes of hydrochloric acid and ammonia in contact, and if this is done in a small room, a sufficient quantity of ammonium chloride is formed and inhaled to produce a decided expectorant action. This is especially useful in the treatment of dyspnoea in children. A fine laryngeal spray of a warm 5 per cent. solution of ammonium chloride may give satisfactory results, but for general utility the internal administration of the drug with heroin meets every demand promptly. Apomorphine hydrochlorate in small doses, one-twenty-fourth grain, is also warmly recommended, and occasionally gives marked relief.

Dyspnoea due to lung congestion and consequent diminished air-space calls for remedies which stimulate the pulmonic circulation, especially the carbonate, salicylate, or iodide of ammonium. In a sthenic patient, with strong heart and increased tension, nitroglycerin will usually give prompt relief. For actual heart fatigue, cardiac tonics and stimulants are needed. In the writer's experience, digitalis fails in febrile conditions, and strychnine and caffeine, preferably in combination, are much more effective. Strychnine is a remarkable tonic stimulant to heart muscle, and caffeine, "the quinine of the heart," assists in maintaining tonicity. Oxygen may be used, but should not exceed 50 per cent. of the air breathed.

Dyspnoea due to spasm of the muscles of respiration or to spasmodic contraction of the molecular coat of the smaller bronchial tubes is relieved immediately by a hypodermic of morphine sulphate, gr. $\frac{1}{4}$, and nitroglycerin, gr. $\frac{1}{30}$. Atropine, gr. $\frac{1}{30}$, can frequently be added with advantage. Where the spasmodic condition is less severe, but prolonged over a longer period, hyoseyamine, in small, repeated doses, is extremely valuable.—*Merck's Archives*, Jan., 1902.

F. Mortimer Lawrence, M.D.

THE HEART STIMULANTS.—At the recent session of the section of Materia Medica, Pharmacy and Therapeutics of the American Medical Association, Patton (Chicago) discussed the indications for and against the administration of digitalis, recommending it for insufficiency and irregularity, but excluding it from the treatment of acute degeneration of the heart. Personally, he had

never observed the cumulative effect of the drug. Strophanthus, spartein, caffein, strychnia and other cardiac stimulants he considered less valuable, strychnia coming next to digitalis.

In the ensuing discussion, Robinson recommended camphor as a good cardiac stimulant, a 10 per cent. solution producing marvelous results. Supra-renal extract was a temporary stimulant, but the results were evanescent. Heinrich Stern expressed himself as strongly in favor of adonidin. Wood (Philadelphia) wanted activity of the heart kept up, and was not in favor of drugs to any extent; supra-renal extract he considered useless in its action on the heart. Cohen advocated the use of digitalin in larger doses than he had at first given, also musk or camphor. He did not agree with Wood as to the effect of adrenalin; it was not inert, and he had seen some very remarkable effects through its being held in the mouth and absorbed by the mucous membrane, and also, through dropping adrenalin into the conjunctiva, had produced wonderful results on the heart.—*American Medicine*, June 21, 1902.

F. Mortimer Lawrence, M.D.

THE CAUSE OF DIABETES MELLITUS.—By experimental investigation, Croftan has determined that the blood and lymph contain an agent that can destroy sugar; that this agent is a ferment present in the leucocytes or plaques; and that degeneration of the leucocytes must occur before the ferment can develop its powers. Removal of the pancreas decreases the glycolytic power of the blood, and that organ is therefore, probably in some way concerned in the manufacture of the glycolytic ferment. It was found that trypsin (a pancreatic ferment), in the presence of hæmoglobin, possesses glycolytic powers, and that the glycolytic ferment of the blood and trypsin, if not identical, are so similar that they cannot be distinguished by known methods. It was further shown that it is by a process of alteration in the formation of bile-pigments and bile acids that the disintegration of the sugar molecule can occur anywhere in the body where hæmoglobin is liberated in the presence of trypsin. A perversion of this glycolytic function must lead to hyperglycæmia and glycosuria, and one is therefore justified in seeing one of the causes, if not the only cause, of diabetes in a reduction of glycolysis. It is not probable, however, that a common cause for this perversion exists in all cases.—*Am. Journ. Med. Sciences*, June, 1902.

F. Mortimer Lawrence, M.D.

INDICATIONS FOR TREATMENT, DIETETIC OR MEDICINAL, IN CASES OF GLYCOSURIA.—(Heinrich Stern (New York), in a paper presented to the A. M. A., notes that little discrimination is exercised between the various types of chronic glycosuria, and acknowledges that, on account of the injudicious prescribing and the polypharmacy of former years, medical treatment has of late been relegated to the rear. He suggests the following generalizations in treatment:

Indications for the institution of dietetic treatment alone:

All patients exhibiting the usual symptoms of diabetes mellitus, whose urine is free from acetone, diacetic and beta-oxybutyric acids should be subjected to strict dietetic regulations until all symptoms have completely subsided, or until all symptoms except glycosuria, which meantime has declined to less than 1 per cent., has disappeared.

Indications for the institution of medical treatment alone :

1. All cases systematically declining under regulation of the diet.
2. All cases in which long-continued, rich diet cannot effectually compel cessation of the glycosuric symptoms.
3. All cases excreting less than 1 per cent. of glucose, in which the patient suffers from some disorder, but does not exhibit the secondary symptom-complex of diabetes mellitus.
4. Cases in which diet has brought about a subsidence of diabetic phenomena, but in which continued mental excitement is liable to effect a recurrence of glycosuria.

Indications for both dietary and medicinal treatment :

1. All cases in which diet and special hygienic treatment are indicated, in which the patient, on account of circumstances, is prevented from properly executing them.
2. All cases exhibiting symptoms of diabetes mellitus, which, by reason of accompanying affections, like chronic nephritis, for instance, cannot be kept under a rigid antidiabetic regimen.—*American Medicine*, June 21, 1902.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF HYPERCHLORHYDRIA.—Einhorn (New York) refers to the controversy between clinicians as to the proper diet for hyperchlorhydria, some forbidding starchy foods entirely, and nourishing their patients by animal diet, while others forbid meats on account of their tendency to produce an increased flow of gastric juice. Another controversy exists as to the frequency of meals, some advising two meals a day, in order to give the stomach a long rest between them, and others prescribing frequent meals, in order to diminish the too great acidity by diluting the stomach contents.

When such differences of opinion exist, personal experience is of value. Einhorn is in favor of frequent meals, three larger ones (breakfast, lunch and supper) and two or three smaller ones (consisting only of milk and bread and butter). The larger meals should consist of foods commonly taken at these meals, with the exception of acid, too greasy and indigestible substances. Meats and eggs (hard-boiled) should preponderate, while all kinds of spices and too highly seasoned foods should be avoided. He always permits patients to take considerable quantities of bread and butter, especially of the latter.

His medicinal treatment consists in administering alkalis one or two hours after meals—plain sodium bicarbonate, or, in case of constipation, sodium bicarbonate with calcined magnesia and sometimes rhubarb. Bromides are of great value in persons with nervous symptoms, such as headaches, sleeplessness and discomfort. He has not seen much benefit from atropine. Intra-gastric faradization and galvanization exert great benefit. A cold compress over the stomach at night is useful, as are cold ablutions followed by a good rubbing of the chest and back. Spraying the stomach with silver nitrate or protargol, or powdering it with supra-renal extract, appears to be of value in obstinate cases.—*American Medicine*, June 21, 1902.

F. Mortimer Lawrence, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY O. S. HAINES, M.D.,
with the collaboration in German literature of C. Sigmund Raue, M.D.

SOME DRUG STUDIES IN RELATION TO RHEUMATISM, GOUT AND LITHÆMIA.—In the June number of the *N. E. Med. Gazette* may be found an interesting paper by the late Richard Hughes, M.D., contributed to the annual meeting of the Mass. Med. Soc., held some time in April. The death of this incomparable exponent of homœopathy was a sad loss to our school. He had a multitude of friends and admirers on this side of the Atlantic, who have always appreciated his indefatigable labors in the interests of the truth and purity of our Materia Medica, and these feel his loss keenly. His influence upon homœopathy will never die. In this little paper Dr. Hughes differentiates gout, rheumatism and lithæmia; and thinks that all our evidence goes to prove, indubitably, that the essence of acute rheumatism is a poison distinct from, though analogous to, that of gout. We admit, very generally, that the latter is uric acid, an excess of which in the blood manifestly favors a gouty outbreak. But the theory that *lactic acid* plays a similar part in acute rheumatism finds little favor nowadays. We think that Dr. Hughes rather favors this view. He thinks we have cogent evidence in favor of it, in the results of the experiments made by Kuelz, and also by B. Foster, both of whom observed symptoms analogous to those of acute rheumatism, after full doses had been prescribed for some time in diabetic cases. In further proof, we might add that Richardson observed the characteristic pleural and cardiac inflammations that occur in acute rheumatism so often, in those animals into whose peritoneal cavities he had previously injected the lactic acid. And, to make the picture still more suggestive, the last observer declares that during life these same animals showed evident signs of pain and tenderness of joints. Instead of recommending us to use lactic acid in rheumatic fevers, Dr. Hughes tells us that these facts should *dissuade* us from employing the drug in the treatment of acute rheumatism, because, in all probability, this substance is the actual *materia morbi*. But they give us reliable data, on the other hand, for the use of this truly homœopathic remedy, when the arthritic and cardiac conditions occur in connection with diseases other than acute rheumatism. It would be worth the while of homœopaths to try the lactic acid in cases of arthritis deformans. There are some cures reported already in our literature, although the descriptions of these cases, from a clinical standpoint, are not exactly what they should be. The author joins his praises to those of our Dr. Goodno, when speaking of the excellent effects to be obtained from colchicum and its alkaloid in acute

rheumatism. Dr. Hughes feels that no formula seems to express the relation of its curative to its pathogenic effects as well as *similia similibus*. The effect of colchicum is probably upon the local manifestation of acute rheumatism rather than upon the fundamental seat of the disease. We have never thought that colchicine was as effective as the dilutions of our homœopathic tincture of colchicum, in those sub-acute gouty cases. And Dr. Colby has spoken, in 1895, upon this same subject. He praises the "vinum" of the British Pharmacopœia, in this class of cases, when the inflammation attacks principally the hands and feet. There is a central tenderness on palpation of the joints, moderate swelling, and a pink blush. There is constant pain during the prevalence of damp, east winds, and especially before a storm. A sense of paralytic weakness may also be present. These cases are apt to be tedious. When he comes to consider lithæmia, Dr. Hughes finds drugs of less importance than the correction of faulty methods of life—a view of the matter in which we heartily concur. The one thing for a patient so afflicted is to diminish the supply of pabulum and to increase oxidation and elimination. Air, exercise, copious water drinking, disuse of alcohol, reduction of the nitrogenous and increase of the fruit element in his diet,—these are measures which will do more for him than all the medicines in the world. Dr. Hughes says he would select *sepia* for a female lithæmic, and *lycopodium* if the case was a male.

THE HOMŒOPATHIC TREATMENT OF SHOCK.—There are a number of our remedies that will prove very useful in the treatment of surgical shock. There are camphora, arnica, cinchona, carbo vegetabilis, and veratrum album. Dr. W. A. Dewey believes that the *veratrum album* will be oftenest indicated. How perfectly its pathogenesis corresponds to a case of severe shock—the coldness of the extremities, the pallor of the face, the relaxed muscles, the imperceptible breathing and the Hippocratic countenance. It surely requires courage to rely on such a remedy as veratrum in potency, in such cases, particularly if one has been in the habit of resorting to cardiac stimulants, spinal stimulants, saline injections and infusions, besides a host of other things that are recommended "for trial." Those who have learned to rely upon the veratrum, and similar remedies, find them safer and surer than strychnine and the rest. Dr. Dewey has seen more than one case of over-stimulation by strychnine. The normal saline solution is not open to the same objections, however. Surgeons certainly neglect our remedies, sometimes, for less effective medicaments.—*N. A. Journal of Hom.*

SOME EXCELLENT INDICATIONS FOR REMEDIES IN INJURIES.—*Arnica*: Blows upon the head, with unconsciousness; vomiting and other evidences of an internal hæmorrhage. In those basilar fractures that come on from injuries, with bleeding from the ears: most of these will die without arnica. We have sometimes thought that the best effects, in such cases, are obtained from the remedy in dilution; not from the tinctures of arnica. This admirable remedy has frequently cured meningitis, apoplexy, loss of consciousness with involuntary evacuations. Characteristic symptoms are boring the head into the pillow, which means basilar head trouble in children, and sometimes in adults. The patient rolls the head as if trying to get it backward into the pillow. In bruises, the parts are soon black and blue, with much exudation of blood and a great deal of tumefaction. Soreness is a prominent symptom

in such cases. Sometimes, following injuries to the head, there is a crushed feeling, as if in the bones, or their articulations. Here *symphytum* will be indicated. If the injury extends to the periosteum, involves the tendons, cartilages and ligaments, *symphytum* is preferable to *arnica*. For instance, sometimes a great bruise occurs over the tibia, where the skin and tissues are thin; *arnica* might cope with the bruised soft parts, but if the periosteum is injured, we should select *ruta*. Vascular states of the periosteum point to *ruta* rather than to *arnica*. After an injury, when the ligaments and tendons are weak and relaxed, or even semi-paralyzed, *rhus tox.* comes in.

We should never forget that *rhus* is followed by *calcarea* with benefit, in many cases, and this is a very practical point. The soreness has disappeared, but the weakness and stiffness remain. When the patients get wet they are more stiff than before. Old fractures and injuries round the joints are stiff and painful. Here we often give *rhus* with benefit, but sometimes the case does not recover perfectly until *calcarea* has been given to complete the work which the *rhus* has begun. This little *resume* has been compiled from the admirable lecture of Dr. Kent upon *arnica*.—*Hahnemannian Advocate*.

THERAPEUTICS OF SMALL-POX.—*Aconite* is a valuable remedy in the stage of invasion. *Gelsemium* or *belladonna*, if the patient is drowsy. *Veratrum viride*, when there is irritable stomach, high fever and small pulse. After eruption is well out, and there is much complaint of burning and itching, give *rhus tox.* in the tincture. *Vaccinium* has been extensively used. (Goodno used this remedy in 60 cases without a fatality.) *Tartar emetic*, perhaps, enjoys the greatest reputation in the treatment of small-pox. Its reputation is well deserved. *Baptisia* was used by Williams, of Bristol, England, in some 72 cases, with perfect success. When pus appears in the eruptions, give *mercurius*. In hæmorrhagic cases, think of *lachesis*, *crotales*, *secale* or *arsenicum*.—Carl. H. Wintsch, M.D., in *N. A. Journal* for June.

ABSTRACTS FROM THE MEETING OF THE HOMŒOPATHIC PHYSICIANS OF HAMBURG.—*The Leipziger Populäre Zeitschrift für Homöopathie*, May, 1902, publishes the following abstracts from the minutes of the Homœopathic Society of Hamburg.

Veratrum Album in Whooping-Cough.—Dr. Martens cited a case of whooping-cough promptly cured with *veratrum alb.* 3d, the remedy being prescribed on the symptom "belching of gas after the paroxysm."

Kali Carbonicum.—Another case of whooping-cough is quoted in which *kali carb.* proved beneficial. Here there was pronounced swelling of the upper eyelids.

Cinnabaris in Neuralgia.—Dr. Martens cited a case of neuralgia in which there was pain both under and over both eyes. The peculiarity of the case was the fact that *cinnabaris* relieved only the pain over the eyes.

Mercurius Corr. in Diabetes.—Dr. Reuter recommends this remedy in diabetes when ulcers develop at the junction of the skin and mucous membrane; also in women, in the presence of irritating vaginal discharges.

Natrum Sulphuricum in Hæmophilia.—In a discussion on hæmophilia, Dr. Reuter stated his belief in the efficacy of *natrum sulphuricum* in the disease. He cited the case of a woman in whom a uterine polyp was removed, the

operation being followed by continuous bleeding for months. She was finally cured with natrum sulphuricum in appreciable doses. Dr. Man cited the case of a woman suffering from an hepatic disturbance, who bled twenty-four hours after the extraction of a tooth. Natrum sulph. promptly restored her to health. From this coincidence, and from the fact that Schuessler accepted natrum sulph. as a prominent live remedy, Dr. Reuter was tempted to infer that hæmophilia was of hepatic origin. Reasoning based on such slender premises is, however, hazardous to indulge in, and we fear that many of our therapeutic recommendations have no stronger legs to stand on than the Reuter natrum sulphuricum cure for hæmophilia.

MULTIPLE NEURITIS FOLLOWED BY EPILEPTIFORM SEIZURES.—Dr. Berlin (*Leipziger Pop. Zeitschrift f. Hom.*) reports a most interesting case of rheumatic multiple neuritis occurring in a young girl after sleeping on a cold floor. When she was brought to him she had been ill for eight days. There was paresis of the extremities, tongue and pharynx. In the beginning, there was pain in the extremities and slight formication. *Aconite* 3d decimal dilution, five drops every three hours, were prescribed, and in the course of three weeks she had recovered. Shortly after, she was seized with epileptiform convulsions, which soon ceased on the administration of *cuprum met.* 6th. They were, however, followed by attacks of petit mal, occurring as high as five times daily. *Artemisia vulgaris*, 1st decimal dilution, five drops four times daily, was prescribed, upon which she made a complete recovery.

NOTES ON ECHINACEA.—Dr. A. L. Engle has recently reported excellent results following the internal use of this remedy in a severe case of rhus tox. poisoning. Dr. Kinne was called to treat a case of carbuncle of the lower lip, which had been progressing for a week. The pain was intense, lip swollen, black, and even with chin. Patient delirious. Two teaspoonfuls of the tincture were dissolved in two-thirds of a glass of water, two teaspoonfuls being administered each hour. The case improved more rapidly than any other case the doctor had seen. Dr. L. B. Swormstedt reports a case of pemphigus in a man aged seventy-nine. The eruption was universal. The dose was about the same as in the case last mentioned. Improvement began in one week, and the case was cured in six weeks. Dr. G. W. Washburn claims that the remedy has never failed him in the treatment of eczema. He uses it freely in syphilis. In the primary stage, locally; to the chancre, ulcerations and mucous patches. Later, he praises it in combination with iris versicolor. He claims that this mixture of the tinctures will succeed in cases that resist the iodides and mercury. In erysipelas he uses it locally—diluted one-half and applied upon compresses. To the eclectic school belongs the credit of introducing this remedy. These brief notes are from *The Homœopathic News*, in the columns of which journal may be found many articles upon echinacea.

PERIODICAL RECURRENCE OF SYMPTOMS.—Dr. Keese, in a paper upon this subject, calls attention to some remedies which have shown a marked periodicity in the occurrence of symptoms.

Aranea diadema.—Many of its symptoms are marked by this periodicity. The chill returns at precisely the same hour; so does its toothache and colics.

Nitric acid, with its every other day aggravation in typhoid fever.

Ipecacuanha has a dyspepsia every day at the same hour; also every alternate day at same hour. It has a bilious vomiting, which is said to return every Saturday.

Cedron must not be forgotten. Its neuralgias return with unerring periodicity to the hour. (We had a case of very severe abdominal neuralgia, which recurred at irregular periods, but always at exactly the same hour. This case was not clear as to its cause and pathology, but it was cured by cedron 3x after many other remedies had failed.)

Alumina has a chronic diarrhœa that is aggravated on alternate days.

Sulphur headaches recur every seventh day.

Natrum mur. has, every spring and fall, symptoms of chills and fever. Also a facial neuralgia or a chill at nine or ten each morning.—*Med. Advance.*

ACONITE IN PEDIATRIC PRACTICE.—Hartmann (*Die Kinderkrankheiten u. ihre Behandlung*) speaks the following words of praise for aconite in the diseases incident to childhood: "The continuing growth and development of the child renders it especially liable to inflammatory disturbances in the brain and chest, beside a series of other symptoms due to irritation of the nervous system, or to a disturbance in the alimentary tract. All can, however, be relieved with a single remedy, as if by magic; namely, aconite, in the finest dosage. Not alone because aconite is the best homœopathic antiphlogistic, but because experiments and observations upon the human organism have demonstrated the similarity of its action to the disturbances noted in the sick child. It is a true panacea in children's diseases, and I would not care to be a children's doctor without it. My faith in this remedy does not, as with many homœopathic physicians, rest in a belief in its antipyretic action, but in the correspondence of the disturbances it produces in the healthy organism with those existing in the sick child.

AN ADDITION TO THE THERAPEUTICS OF EXOPHTHALMIC GOITRE.—Dr. W. O. Fryberger has written a short article upon the treatment of exophthalmic goitre in *Clinique* for June 15th which, like a great many of the papers in that journal, is crisp and to the point. He first tells us of the general measures he has found useful, and then says: "My patients did not get well until I began using the tincture of fucus vesiculosus, in thirty-drop doses." He has observed that the patient begins to gain in weight soon after the remedy is administered, and he thinks that a gain in bodily weight and "getting well" are almost synonymous terms in this affection. He gives the remedy three times each day, and the course of curative treatment lasts, on an average, from six months to a year. He remarks that sometimes the patients will not begin to improve at once, but for a few days there may be an aggravation of some symptoms, and that these latter can be prescribed for in the usual manner. At the same time, he sticks steadily to the fucus. This observation is valuable, and should receive further confirmation. A very valuable adjuvant in such cases is the application of galvanism,—the galvanic current. The anode is placed upon the nape of the neck, and the cathode is moved up and down the sides of the gland. We should use a very mild current; two or three mil., applied every other day for fifteen minutes, is enough.

THE INCOMPETENCY OF FATTY HEARTS.—The fatty heart, particularly the degenerative form, takes away the cardiac muscular resistance, and hence this pathology always predisposes to a form of insufficiency. Unfortunately, we too infrequently think of the diagnosis in this respect; the common error is to consider it a lagging heart which needs the excitement of stimulation. The proper remedies are not usually the unmerciful cardiac stimulants. We should first think of arsenicum, because of the predisposition to anaemia. We should next direct our attention to phosphorus, because it is the pathological similitum of fatty degeneration. We should keep an eye open for the indications of sulphur, because of any possible dyscrasia. We should keep in mind aurum, inasmuch as a fibrous increase may follow the fatty degeneration. In cases in which a tonic effect seems very desirable, we should exercise the greatest caution in the selection of our cardiac tonic.—Halbert, in *Clinique*, June 15th.

LILIUM TIGRINUM IN MITRAL INSUFFICIENCY.—In a case of slight mitral insufficiency which developed from a previous anæmic condition, Dr. Halbert obtained good effects from lilium. The apex was not displaced to any extent, but there was some hypertrophy. This occurs frequently in women, as a reflex condition occurring in connection with some uterine disturbance. There is a sense of weight and pressure in the uterine region. The cardiac symptoms are: Dull, pressive pain, with sensation of weight. Aggravation upon lying. The heart may feel as if squeezed in a vise. Sharp, quick pains are felt in the region of the heart, followed by palpitations. Coldness and weakness of the lower limbs. These are all symptoms that should suggest the use of lilium tigrinum in such a case.—*Clinique* for May.

RE-PROVING VERSUS RECONFIRMATIONS.—Dr. M. W. Vandenburg thinks that we need, in our school, a multitude of reconfirmations, gathered from the widest possible fields and from the greatest possible numbers. In this he sees a means of developing a reliable and thoroughly practical materia medica. It is pretty clearly demonstrated that neither this generation nor the next will reap much benefit from the re-proving of drugs. The *value* of any given symptom must be demonstrated empirically before it can be proven how effective the drug will be in therapeutic use. Every practitioner may and must find out for himself the reliability or unreliability of any given symptom or group of symptoms. We, of this generation, are afraid to prove drugs in the way and to the extent necessary for our purpose. Medical patriotism is at a low ebb just now. So long as we fail to recognize the magnitude of the wastefulness of the present time that lies in neglect to collect, classify, scrutinize and publish our confirmations in a reliable and practical manner, this wastefulness will continue.—*Advocate*.

PHOSPHORUS IN NAUSEA.—Dr. J. C. Fahnestock calls attention to the value of phosphorus, 30th and 200th, in the nausea following chloroform anaesthesia.—*Century*.

A "REGULAR" LECTURE ON HOMŒOPATHY.—On the evening of March 7, 1902, Prof. Charles Mitchell delivered an interesting address upon homœopathy in the amphitheatre of the University of Maryland. On the whole, the address exhibits a breadth of view and a charity of opinion which is refreshing, and which proves that homœopathy is making some way in

the most unexpected quarters. No one of those who listened to Dr. Mitchell will ever look upon homœopathy as a matter for ridicule, but must ever regard it, and those who practice it, with respect.—*The American Medical Monthly*. If the ancient school of medicine ever does set about investigating the homœopathic law of drug selection, and the homœopathic method of drug proving, there will be some happenings that will make homœopaths look to their laurels. The great fault with our school is, that we don't appreciate what a good thing we have got. "All true appreciation is the result of keen insight."

FERRUM METALLICUM IN ITCHING OF ANUS DUE TO ASCARIDES.—Itching of the anus in young children occurs, nearly always, soon after they have been put to bed. The child is then restless, kicks, throws its legs about, claws at the anus, rolls over and cries out, and in a moment more goes to sleep again. This performance is repeated again and again. If you examine the anus by pulling the nates apart, you will find it redder than natural, showing irritation from some cause,—probably ascarides. The 30th or 200th potency of ferrum, repeated daily, has cured almost all of Dr. Wakeman's causes; and he has had many of this kind during his practice.—*American Med. Monthly*.

KALMIA IN RHEUMATIC ENDOCARDITIS.—A man, aged 22, who had suffered from an attack of rheumatic fever, showed, after four months, the following effects of his illness: He was still sore and stiff about the joints, and suffered from muscular pains. But shortness of breath and oppression were even more serious. He had stitching pains about the heart, palpitation, and a weak, slow, feeble pulse. An examination showed the heart to be dilated. The apex beat was diffused, and a systolic murmur, loudest at the apex, could be heard. He was advised to go to bed, to put as little strain as possible upon the myocardium, and given kalmia latifolia 3x. After a few weeks' treatment it was impossible to hear a murmur, compensation was perfect, and he felt quite well.—*Reported by A. L. Blackwood, M.D.*

POPULUS MONILIFERA IN MALARIAL HÆMATURIA.—Dr. W. M. Alter has used this remedy for twenty-seven years in malarious affections, and claims that it cures thoroughly even those chronic and irregular forms that resist the action of quinine. But his most interesting observation relates to the efficacy of this remedy in that very troublesome and persistent affection, malarial hæmaturia. He claims that the drug is a real specific in this affection. The author probably used a strong infusion of the bark in his cases. His practice has been confined to a district in which malarious diseases are common, so that his claims are based upon considerable practical experience.—*Eclectic Medical Journal*.

THE MEDICAL AND SURGICAL TREATMENT OF ENLARGED GLANDS.—Any one who has had brilliant success in the medicinal treatment of enlarged glands, and is willing to talk about it, can have the undivided attention of the profession at any and at all times. Thus it is that the paper by Dr. W. Louis Hartman, in *Century* for May, is one that attracts immediate attention, because its author says, in the beginning, that he used to meet with disappointments, but that now "I have not such failures." His treatment is both medical and surgical. He begins the medical treatment when the glands are first noticed to be enlarging, and continues it faithfully. His remedies are calcarea iodata, silica, and an external application of iodoform ointment.

He complains of previous failures with the ordinary preparation of iodide of lime, but praises the good effects of the dark iodide of lime manufactured by a certain "Boston firm." We do not know to which firm he refers, but there is a preparation of dark iodide of lime made by Messrs. Billings, Clapp & Co., of Boston, after the formula of Nicholls, so we conclude that the author has reference to that preparation. This he triturates or dilutes with water to the first decimal, and prescribes it in doses of one-tenth grain.

It will not cure cases in which the glands have already broken down. In croupy children, of a strumous diathesis, the remedy will cure not only the glandular enlargements, but also the croup and the croupy tendencies. The author claims that this particular preparation of lime will also help the sore glands of pseudoleukemia. When the stage of suppuration has been reached, silica can be prescribed with more confidence. As a local application, especially in tubercular glands, iodoform ointment is of paramount importance. It should be well rubbed into the skin at bedtime and a bandage applied. Dr. Hartman prepares his ointment as follows: The base is composed of equal parts of vaselin and lanolin; the ointment is then made by adding 10 per cent. of iodoform. Mountain air is a decidedly useful adjuvant to the medicinal management of these cases. The author then refers to the surgical treatment of suppurating glands.

SOME COMMON RECTAL TROUBLES AND THEIR TREATMENT.—Dudley Wright, F.R.C.S., surgeon to the London Homœopathic Hospital, in a practical and concisely-worded article in June *London Hom. Review*, points out the methods we should follow in order to avoid the pain and distress so common in complete rectal examinations. He directs that about 40 minims of a 5 per cent. cocaine solution be injected into the rectum above the internal sphincter. For this purpose, nothing is more handy than an Ultzmann's urethral syringe, to which has been attached three inches of a No. 5 gum elastic catheter.

On withdrawing the nozzle through the anal canal, the last portion of this solution may be expelled, so that this portion of the passage may be also rendered insensitive. Of course, the bowels should have been thoroughly emptied before beginning, and it also aids much in the examination if the patient be given, just before examining, an injection of hot water, which he is to expel by rather forcible straining. The procedure brings the pile masses and the redundant mucous membranes outside the anus. Now, everting the margins of the anus, we are to look for fissures, etc., after which the speculum may be inserted. Dr. Wright prefers a hollow vulcanite cylinder, three inches long and three-quarter inch in diameter, fitted with a movable metal plug.

Fissure of the anus and irritable ulcer are particularly associated with a certain set of conditions. The majority of the patients are of the nervo-sanguine temperament, thin, wiry; and, having dry skins, fissures occur from slight causes. Constipation is also present, and may prove to be the exciting cause of the fissure. The remedies of most value for fissures and painful ulcers are, in the experience of the author, nux vom., graphites and nitric acid. Dr. Wright gives nux 3 night and morning, and graphites 6 before each meal. He has found this method of medication of immense service. This method of prescribing should not be too severely criticised. It is homœopathic prescribing, yet it cannot be said to be the consummation of homœopathic art.

Cleanliness in these cases is most important. After each stool, the anus is to be washed with soap and water and anointed with a simple oil or lubricating ointment. Remedies proving ineffective, we are advised to thoroughly anaesthetize the fissure and surrounding tissue, and then "run a fine knife along it, so as to divide the greater part of the external sphincter and a quarter of an inch of skin and mucous membrane at either end."

Dr. Wright treats his cases of hæmorrhoids and prolapsed anus by injections of hazeline and carbolic acid. An important rule to follow is: Inject but a small amount; 5 to 10 minims are enough. Deposit the fluid in the sub-mucous tissue, and not in the muscular wall of the bowel. If the sphincter is very tight, a preliminary dilatation is beneficial. A suppository containing 1 grain of hamamelis, 20 minims of tincture hydrastis and the same quantity of æsculus, in cocoa-butter, is highly recommended as a useful adjuvant. His injection fluid consists of equal parts of hazeline and distilled water, to which has been added 10 per cent. carbolic acid.

ROBINIA PSEUDO-ACACIA: ITS USES IN STOMACH AFFECTIONS.—Dr. Frederick Kopp, of N. S. W., writes entertainingly of the reliability of this remedy in the treatment of acid states of the stomach. We feel sure this method of treating "an acid stomach" is far preferable to the administration of chalk, soda and other alkalies.

The robinia has for its analogues such drugs as pulsatilla, rheum, magnesia carb. and iris. At times its pathogenesis brings to our mind bryonia or colocynth, but it is a superficial resemblance only. The robinia patient is irritable and low-spirited, a common mental state in acidity. A dull frontal headache, or even sharper neuralgic pains in the temples, are common. The duller pains are much aggravated as the patient moves about. Or, again, our robinia patient may suffer from what might be termed "a sick headache." Then acid eructations and vomiting of *an intensely sour* matter will surely be present. We must remember that in robinia the vomiting will be characterized by a fluid so *sour* that it "sets the teeth on edge." Accompanying this, we will likely find the stomach and bowels distended with flatulence, and, in the case of the intestines, we shall have an accompanying *colic*, which is severe enough to double the patient. Heavy, dull, contracting pains occur in the stomach. The acidity and heartburn prevent sleep at night, and, should the patient have partaken of water before retiring, it will be vomited next morning, greenish in color and intensely sour.

Constipation may accompany the former complaints; a desire for stool, followed by simply a discharge of flatus. Two or three minims of the 2x dilution, repeated every two or three hours, will cure such a patient of his acidity very promptly.—*Homœopathic World*, June 2d.

DIPHThERIA.—Dr. J. Martin Kershaw says that he has always been afraid of the subjects of diphtheria who have weak stomachs, and who have to be constantly coaxed to eat and to drink. Good eaters, and those who will take champagne or whiskey, stand the best chance of getting well. The author's considerable experience, during the past twenty years, leads him to believe antitoxin to be the surest remedy for diphtheria. He does not believe, however, in the immunizing use of antitoxin. It should never be administered save in cases of true diphtheria. Antitoxin, having no diphtheritic condition to *antagonize*, may prove fatal, because of its own poisonous qualities.—*Clinical Reporter*.

THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER.

A Medical Newspaper.

EDITED BY
HERBERT P. LEOPOLD, M.D.

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A Practical Treatise on Small-Pox. Illustrated by colored photographs from life. By George Henry Fox, A.M., M.D., Consulting Dermatologist to the Health Department of New York City, with the collaboration of S. D. Hubbard, M.D., S. Pollitzer, M.D., and J. H. Huddleston, M.D. In two parts. Philadelphia and London: J. B. Lippincott Company. 1902.

The epidemic of small-pox which has invaded every section of the country during the past two years has been responsible for a rude shock to the younger practitioners at least; for they have discovered that the diagnosis of the disease is not always easy. The older men, who met the disease before wholesale vaccination had all but annihilated that greatest of human scourges, may have

had little difficulty ; but the present generation of physicians has rarely, until now, been called upon to detect and combat the disease, and most of them knew little more concerning it than the traditional "shotty feel" and other text-book signs. We need not feel surprised, therefore, because the authorities of the Municipal Hospital in Philadelphia report that nearly half of the alleged small-pox patients sent them were actually suffering from other diseases. Such familiar diseases as measles, and even common acne, have at times been thus mistaken ; while on the other hand, and yet more unfortunately, some cases of true small-pox have been passed over as varieties of the more common affections.

Under these circumstances it is fortunate for the profession that Dr. Fox has brought together this magnificent collection of plates. So true to life is the coloring, so typical are the cases, that scarcely an excuse will be left the possessor of this work for failure to recognize small-pox on sight. Every stage and every variety of variola is pictured, while the accompanying text affords complete details as to symptoms, diagnosis, and treatment. Many previous articles on variola have been illustrated by a few photographs of cases, mostly of the pustular type, but this work is the first which has presented illustrations of small-pox in each of its successive stages. It is, in consequence, a book which is apt to be sorely needed at times in every physician's office.

Diseases of the Nose, Pharynx, and Ear. By Henry Gradle, M.D., Professor of Ophthalmology and Otology, Northwestern University Medical School, Chicago. Handsome octavo of 547 pages, profusely illustrated, including two full-page plates in colors. Philadelphia and London: W. B. Saunders & Co. 1902. Cloth, \$3.50 net.

This volume is intended to present diseases of the nose, pharynx, and ear, as the author has seen them during an experience of nearly twenty-five years. In it are answered in detail those questions regarding the course and outcome of diseases which cause the less experienced observer the most anxiety in an individual case, questions to which an answer is not easily obtained from text-books. In the therapeutic part of the work the author has given detail only to those procedures which have withstood the test of critical experience. Topographic anatomy being a requisite for all surgical work, the author has wisely devoted liberal space to this branch of the subject. The numerous illustrations are exceptionally accurate in their portrayal of the pathologic conditions, especially so the two full-page colored plates. We know of no work of its size that is at the same time so useful a text-book and so excellent a work of reference.

Diseases of the Lungs. Their Pathology, Symptomatology, Diagnosis and Treatment. By Ch. Gatchell, M.D., Attending Physician to Cook County Hospital, Chicago ; formerly Professor of the Principles and Practice of Medicine in the University of Michigan ; Author of "Pocket-Book of Medical Practice ;" Editor of the "Medical Era ;" Secretary of the American Institute of Homœopathy. Chicago: Era Publishing Company. 1902. 264 pages. \$2.00.

A story is told of the elder Gross to the effect that a medical friend sought his advice by mail concerning one of his cases. The letter went into particulars in a most tiresome way, and covered several pages of paper. The recipient, in reply, simply wrote, "Dear Doctor: Cut. Yours, Gross." He wasted no words. He was a good example to all letter-writers and authors. Now we are reminded of this story because Gatchell wastes no words. This means, incidentally, that he wastes none of the time of his readers. Two hundred and sixty-four pages afford plenty of room for a disquisition on the lungs,

but when words are saved as if they were golden, the book blossoms forth as a veritable encyclopædia of information. Symptomatology, pathology, etiology and treatment of pulmonary disorders are given completely and with accuracy. The arrangement of the text is such that the searcher for information can almost at a glance find any subject for which he seeks.

The Artificial Feeding of Infants. Including a Critical Review of the recent literature of the subject. By Chas. F. Judson, M.D., Physician to the Medical Dispensary of the Children's Hospital, and J. Claxton Gittings, M.D., Assistant Physician to the Medical Dispensary of the Children's Hospital. Philadelphia: J. B. Lippincott Co. 1902.

The aim of this work is to place before the medical profession a thorough and reliable account of the principles and methods of artificial feeding in vogue at the present day. Much valuable material not contained in the average text-book has been collected, representing the results of extended scientific investigations. The substance of this work has been gleaned from the periodical literature, monographs and text-books of the past eight years; so that this treatise may justly claim to be an authoritative statement of the views of the leading pædiatrists and scientists of Europe and America on the subject of artificial feeding at the present day.

Wharton's Minor Surgery and Bandaging. New (5th) edition, thoroughly revised. A Manual of Minor Surgery and Bandaging. By Henry R. Wharton, M.D., Professor of Clinical Surgery in the Woman's Medical College, Surgeon to the Presbyterian Hospital, Philadelphia, etc. In one 12mo. volume of 612 pages, with 509 illustrations, many of which are photographic. Cloth, \$3.00 net. Lea Brothers & Co., Publishers, Philadelphia and New York.

The author has endeavored to present a concise description of the various bandages, surgical dressings, and minor surgical procedures employed in the practice of surgery at the present time. The preparation and application of aseptic and antiseptic dressings have also received full consideration, and the importance of surgical bacteriology is recognized in a special chapter. The article on bandages is fully illustrated with cuts, chiefly photographic, which furnish an accurate and clear representation of the most important bandages used in surgical practice. The same is, in a measure, true of the section upon fractures and dislocations, which is likewise photographically illustrated. The work also contains short articles on tracheotomy, intubation, ligation of arteries and amputations. In view of the great attention now paid in our medical schools to operative procedures on the cadaver and the importance of this method of instruction, a section on this subject has been added. A call for five editions is no idle compliment, and the author is to be congratulated that he has had such numerous opportunities to keep the work abreast with the advance of medical and surgical science.

American Edition of Nothnagel's Encyclopedia. Diphtheria, Measles, Scarlet Fever, and German Measles.—Diphtheria. By William P. Northrup, M.D., of New York. Measles, Scarlet Fever, and German Measles. By Professor Dr. Th. von Jurgensen, Professor of Medicine in the University of Tübingen. Edited, with additions, by William P. Northrup, M.D., Professor of Pædiatrics in the University and Bellevue Medical College, New York. Handsome octavo, 672 pages, illustrated, including 24 full-page plates, 3 of them in colors. Philadelphia and London: W. B. Saunders & Co. 1902. Cloth, \$5.00 net; Half-Morocco, \$9.00 net.

This volume, the third in the series of English translations of the "Nothnagel System of Practical Medicine," needs no recommendation. Professor

Jurgensen and Dr. Northrup are too well known for us to expect anything but the best. The article on "Diphtheria," entirely original with the editor, is fully in keeping with the high standard set by the other German articles which comprise the work. Dr. Northrup, having been associated with Dr. O'Dwyer at every step in the perfection of intubation tubes, is particularly fitted to describe this aspect of the treatment of diphtheria. We have been especially impressed with the text and illustrations of this portion of the work. Not only has every step of the operation been fully demonstrated on paper, but skiagraphic illustrations of the tube in its various positions are also presented.

Professor Jurgensen's monograph on "Measles" unquestionably is the most comprehensive contribution on that infection that has appeared, bringing out so fully the valuable Danish records of the Faroe Islands epidemic. His exposition of "Scarlatina" is unrivaled both for richness of clinical detail and exactness and clearness of statement. "Fourth Disease" and "German Measles" have been accorded spaces consistent with their importance. The editor has shown judicious decision in his extensive additions, making the work far and away the best and most up-to-date treatise of the subjects extant. The book is profusely illustrated, containing, besides a large number of text-cuts, twenty-four full-page plates, three of which are in colors.

New York Letter.—The Academy of Pathological Science held a meeting on Friday evening, May 23d, at the residence of Dr. Irving Townsend, 67 West 46th street, with a programme as follows: Skiagraphs as Aids in Diagnosis; An X-Ray Self-Regulating Tube, Dr. Wm. H. Dieffenbach; Multiple Abscess of Kidney, Lympho-Sarcoma from Post-Rectal Cellular Tissue, Pyosalpinx, Dr. Wm. F. Honan; Beckmann's Apparatus for Determining the Freezing-point of Urine and Blood, Acute Endocarditis, Fibroid Phthisis, Anomalous Vermiform Appendix, Tubercular Ulcers of Intestine (with specimens from Metropolitan Hospital), Dr. George F. Laidlaw; Tubercular Peritonitis (second presentation of patient since operation, one year ago), Carcinoma of Rectum Removed by the Abdomino-Perineal Route; Gangrenous Appendix, Extra-Uterine Pregnancy, Gonorrhœal Salpingitis and Ovaritis (clinical history by Dr. W. S. Mills), Dr. Geo. W. Roberts.

Metropolitan Hospital.—Dr. Egbert Guernsey, whose health is much improved, entertained the medical board with a collation after the last regular meeting.

Four vacancies for internes will be filled by competitive examination in October, the service to date from December 1.

Dr. E. G. Rankin has issued the first report of the Tuberculosis Infirmary established on January 31, 1902, by the Charities Commissioner, Hon. Homer Folks. The report is interesting and complete. The second annex for tuberculous cases has recently been opened, and the death-rate decidedly lowered in the past month. These cases now being confined to the separate pavilions of the Tuberculosis Infirmary, the beds of the wards in the main building of the Metropolitan are now filled with cases (600 at present) belonging to all other classes of general diseases, with surgical, nose and throat, eye and ear, genito-urinary, gynæcological, and cases in every department. General and sectional bedside clinics for the benefit of the senior class of the N. Y. H. M. College will be conducted at the Metropolitan by the different professors the coming year.

The Homœopathic County Society of New York held its regular meeting on Thursday evening, June 12th. Five candidates were elected to membership and fifteen corresponding members were elected. The reports of committees were omitted and the programme devoted to the memory of Prof. William Tod Helmuth, A.M., M.D., LL.D. The special committee, Drs. Wetmore, Bald-

win, and St. Clair Smith, presented resolutions, which were adopted by a rising vote; the report of the necrologist was read by Dr. J. Hutchinson. The following gentlemen made memorial addresses: Drs. James H. McClelland, Pittsburg, Penn.; Pemberton Dudley, Philadelphia; Hamilton Biggar, Cleveland, Ohio; Theo. Y. Kinne, Paterson, N. J.; Wm. S. Searle, Brooklyn; and Drs. Danforth, King and Dowling, of New York. The attendance was large.

The New York Homœopathic Medical College and Hospital has issued a preliminary announcement, the 43d annual prospectus having been delayed for the reorganization of the Faculty, owing to the death of the Dean, William Tod Helmuth. The list of officers and professors for the session of 1902-1903 is as follows: *Dean*, Wm. Harvey King, M.D.; *Secretary*, George W. Roberts, Ph.B., M.D.; *Registrar*, Wm. H. Bishop, M.D.

Professors of Materia Medica and Therapeutics.—T. F. Allen, A.M., M.D., LL.D. (Emeritus); George H. Shelton, M.D. (Emeritus); St. Clair Smith, M.D.; Paul Allen, M.D.; Edmund Carleton, M.D. (Homœopathic Philosophy with its Clinical Application); E. B. Nash, M.D.; W. I. Pierce, M.D.; J. Perry Seward, A.B., M.D.

Professor of Electro-Therapeutics.—W. H. King, M.D.

Professors of Theory and Practice.—Martin Deschere, M.D. (Emeritus); J. W. Dowling, A.B., M.D.; Frederick J. Nott, A.M., M.D.; J. T. O'Connor, Ph.D., M.D.; E. Guernsey Rankin, A.M., M.D.; J. T. Simonson, M.D.; S. H. Talcott, A.M., M.D.

Professors of Surgery.—Wm. Tod Helmuth, M.D.; Clinton L. Bagg, M.D.; W. H. Bishop, M.D.; B. G. Carleton, M.D.; G. W. Roberts, M.D., Ph.B.

Professors of Gynecology.—E. M. Kellogg, A.B., M.D. (Emeritus); F. E. Doughty, M.D.; E. G. Tuttle, A.M., M.D.

Professor of Obstetrics.—L. L. Danforth, M.D.

Professor of Ophthalmology.—A. B. Norton, M.D.

Professor of Otology.—George W. McDowell, A.M., M.D.

Professor of Laryngology and Rhinology.—C. E. Teets, M.D.

Professor of Dermatology.—H. M. Dearborn, M.D.

Professor of Pathology and Bacteriology.—Louis Heitzmann, M.D.

Professor of Anatomy.—H. B. Minton, M.D.

Professor of Physiology, Hygiene and Dietetics.—Charles McDowell, M.D.

Professor of Chemistry.—J. S. Adriance, A.M., Ph.D.

Professor of Histology.—E. S. Munson, M.D.

Professor of Medical Jurisprudence.—R. H. Lyons, Esq. (Emeritus), Hon. J. M. Dencl.

Attention is called to the changes in the way of promotions and to the addition of names.

The Dean, Prof. Wm. Harvey King, in his Department of Physical and Physiological Therapeutics, will, with a corps of able assistants, present a course of lectures on Suggestive, Hydro- and Mechanical Therapeutics, with a full course upon "Electro-Therapeutics and Physiological Materia Medica as Adjuncts to Homœopathic Treatment."

The features of the college will be thorough didactic instruction and laboratory work in the Junior years, and practical work and clinical demonstrations in the Senior year. Clinical facilities are unequalled, being greater than ever before, Flower, Metropolitan, Ophthalmic and Laura Franklin Hospitals furnishing material from a total of over 1300 beds.

The annual announcement will be issued in a few days, and can be had from the Secretary, Dr. George W. Roberts, 170 West 59th Street.

John Hutchinson, M.D.

Rochester News.—After passing the winter in comparative immunity from small-pox, Rochester is now on the verge of an epidemic. During May and the early part of June, several persons were taken with the disease, and with these as centres of infection, other cases have occurred, and been reported to the number of forty-eight up to June 14th. Two deaths have thus far resulted; several are nearly ready to return to their homes from the city isolation hospital. The Board of Health, the first week in June, asked for an appropriation of \$50,000 for the purpose of combating the disease, but the Common Council saw fit, after some wrangling, to allow only \$25,000. Several aldermen endeavored to belittle the gravity of the situation and the methods of Health Officer Goler, characterizing the publicity given as a needless scare, and decrying the efforts of the Health Board towards lessening the liability of a spread of the disease as a political move.

These same public servants sneered at the efforts of the last year's board in connection with the rabies scare, as they called it, of the past year. It is to be hoped that a day of enlightenment will come to these unafraid but benighted heroes. Dr. Goler, Rochester's Health Officer, has personally attended the patients thus far, and used all necessary care in the treatment of the situation. As all cases have been removed to the isolation hospital before the eruptive stage of the disease, and as hot weather is at hand, it is hoped that the further spread of the scourge will be prevented.

Seventy physicians will be appointed to make a house to house vaccination.

While the people are not as yet alarmed, physicians are unusually busy at this otherwise dull season of the year.

The commencement exercises of the Rochester Homœopathic Training-School took place Thursday evening, June 12th, at the Alumni Gymnasium of the Rochester University. The Rev. Murray A. Bartlett, rector of St. Paul's Episcopal Church, made a most interesting and stirring address to the sixteen graduating nurses before a large audience. Dr. E. H. Wolcott made the presentation address, and Mrs. Hiram W. Sibley, President of the Training-School Board, presented the diplomas. After the exercises, an informal reception was held in the hospital parlors, with dancing and refreshments.

Dr. Edwin H. Walcott has been chosen as Director-in-Chief of the Proving Club to be shortly started in Rochester.

W. W. Winans, M.D.

Washington Letter.—The regular monthly meeting of the Washington Homœopathic Medical Society was held at "The Shoreham" on Tuesday, June 3d. Papers were read by Dr. M. M. Moffitt on "Are We Homœopaths?" and Dr. J. A. Farro on "Some Complication of Inflammation of the Appendix." Both were ably presented, and much discussed and appreciated by the members present.

Dr. J. B. G. Custis and Dr. T. L. Macdonald were re-elected to serve upon the district examining board for three years term.

Dr. Krogstad was among those of Washington who attended the fifty-fourth commencement of the Hahnemann Medical College, on May 15th.

Dr. K. B. Babbitt, who has been away on a trip to the oil-fields of Texas, has returned to the city.

Dr. Ira W. Dennison, we regret to say, had a serious fall from his bicycle, causing a fracture at the elbow. Dr. Macdonald is in attendance.

Dr. H. H. Hawxhurst and family have gone to the Blue Ridge mountains, in Washington county, Maryland, for the heated season.

Mr. and Mrs. W. D. Anderson announce the marriage of their daughter Minnie to Dr. Arthur C. Rauterberg, on June 2d, at Norfolk, Va. At home, after July 1st, at 511 3d Street, N. W., Washington.

New Treatment for Leprosy.—The South American plant called tua-tua, having properties highly lauded as efficacious in leprosy, is under investigation by Dr. Shorey, Food Inspector of Honolulu Board of Health, who is conducting experiments looking toward the ascertaining of the specific qualities of the plant.

Bill Defeated.—The bill to permit the retirement of Surgeon-General Sternberg with rank of Major-General was defeated in the House June 2d.

Naval Service.—All vacancies in the Naval Medical Service are now filled for the first time since the Civil War. This is caused by the act of Congress improving the conditions of services, and placing the medical men of the navy on the same footing as that enjoyed by the army medical corps.

Co-operation of the Army and Navy in medical educational matters is improved by the recent removal of the medical school at Brooklyn Navy Yard to Washington, where it will be used to teach young officers immediately after joining the medical corps of the navy. The naval officers will attend the lectures given by the army medical corps, and the latter will attend the naval school occasionally.

Johnson Memorial Hospital.—In recognition of the services rendered by the late Dr. W. W. Johnson to the medical profession in general and to Columbian University Hospital in particular, the new building now in process of erection by that institution will be known as the Johnson Memorial Hospital.

Medical Inspectors for Schools.—The draft of the new bill sent to the Senate District Committee by the District Commissioners relative to the appointment of medical inspectors for public schools, is as follows: "For eleven medical inspectors of public schools, to be appointed by the Board of Education of the District of Columbia, at \$500 each, \$5500. *Provided*, That said inspectors shall have had at least five years' experience in the practice of medicine in the District, and shall only be appointed after competitive examination."

Macpherson Crichton, M.D.

Removals.—Dr. Harold B. Drake has removed from Portland, Oregon, to Detroit, Mich.

Dr. P. Howe, of Pomona, Cal., has removed to Santa Ana, Cal.

S. B. Van Dalsem, Hahnemann, 1902, has located at Blue Lake, Cal.

Personals.—Dr. Wm. Francis Honan will, as usual, be at "The Mathewson," Narragansett Pier, Rhode Island, during July and August.

Dr. A. B. Lichtenwalner, of 2435 N. 7th St., announces that from June 15th to September 15th his office hours will be as follows: Daily, from 9 to 11 A.M. Monday, Wednesday and Friday evenings from 5 to 7.30; Sunday until 11 A.M. only. Other hours by appointment.

Dr. Nelson C. Scudder, of Rome, N. Y., has been appointed Examining Surgeon to the Bureau of Pensions. Dr. Scudder is a graduate of Hahnemann Medical College, Philadelphia, 1879.

Dr. John Wilson has located at 23 E. 45th Street, New York City. Nervous and mental diseases exclusively.

Dr. W. J. Prish (successor to Dr. A. J. Evans) is located at 79 East Main Street, Fredonia, N. Y.

Dr. Irving Townsend, of New York, desires to announce that he will be in his office (excepting Sundays and the week beginning June 15th) until the 15th of July. From July 15th to August 15th, on Wednesdays and Thursdays only, after which he expects to be away until September 15th.

Dr. Robert M. Jones, his associate, will assume the care of patients, and will be in Dr. Townsend's office daily during his absence.

Dr. John L. Moffat announces that he will be in the city throughout the summer at 1136 Dean Street, Brooklyn.

Dr. Edward G. Bodenbender, of 660 Walden Avenue, Buffalo, N. Y., has been appointed District Physician. He has also been appointed Health Officer of Sloan, N. Y., a thriving suburb of Buffalo.

Married.—Mrs. H. P. Engelman announces the marriage of her granddaughter, Mary Alice Evans, to Dr. David Bushrod James, on Tuesday evening, June 3d. At home, after September 15th, at 2005 N. Twelfth Street.

For Sale.—A physician with a well-established practice of twenty years is obliged to retire because of ill health. He wishes to sell his property, and will give good-will with the same. He will introduce purchaser to his patients. Address, Aubrey J. Richardson, M.D., 1217 E. Susquehanna Ave., Phila.

For Sale to a Homœopath.—The late residence of a homœopathic physician, with practice and good-will. Large country practice, established for thirty-seven years, in a village of 1200 inhabitants, in a rich farming and manufacturing community. No other homœopath within a radius of eleven miles. To be sold by the estate because of the death of the late incumbent. Excellent opportunity. For terms, address Oliver Lentz, Attorney-at-Law, 522 Washington Street, Reading, Pa.

Correspondence.

The following was sent to a prominent medical weekly and declined publication. The editor agreed with the writer, but thought the publication of the letter inadvisable.

PHILADELPHIA, PA., April 28, 1902.

To the Editor of the ———.

The address of Dr. Charles A. L. Reed, delivered before the Physicians' Club, of Dayton, and appearing in your issue of April 19th, is a plea for the unification of the medical profession by accepting as members those who may apply, subject only to such a censorship as may be exercised over any legal practitioner of medicine. In other words, it is a plea for amalgamation, for which, in times past, numerous efforts have been made, without, however, any other apparent result than to disappoint anew the advocates of this greatly desired relationship, except, it may be, that, just as the rock will finally be washed away by the continual dropping of water on its surface, so the frequent attempts at reconciling differences among the divisions of the medical profession, while not effective of immediate results, give much promise of final consummation. A man who stands so prominently in his profession as does Dr. Reed, must necessarily be very brave to have uttered such a sentence as this: "One may look forward with confidence to the meeting to be held in Saratoga in June as the date which shall mark the close of that period in our national profession when a reputable physician shall be denied recognition and fellowship because he exercises the most fundamental prerogative of individual liberty."

In Philadelphia, the animosity of the dominant school towards the Homœopathic branch of the profession is so great that I imagine any one here who would dare advocate such a recognition as recommended by Dr. Reed would have charges very promptly preferred against him by his fellow-members.

I am sure he would soon feel the strong arm of condemnation, and that the fear of this has served to take away from the members of the dominant medical profession here that spirit which, as Dr. Reed says, should control our profession, and keeps them from following that unwritten code of the gentleman which should control the personal conduct and the professional relations of the members of the profession.

In 1880 I graduated from the medical department of the University of Pennsylvania, and shortly after I was made adjunct professor in the Medico-Chirurgical College, then forming in this city. My chief preferred charges against me for instructing my classes in the homœopathic view of the action of remedies, which instruction was collateral to the teaching of recognized views of the dominant school. The ensuing trial was interesting in that only my accuser found it in his heart to vote for conviction. My confession was complete, but every member of the faculty except, as I have said, my accuser, complimented me on my efforts to teach my subject "from all its sides." I was not to be deluded, however, by this vindication. The men who spoke and voted in my favor were my friends, and they voiced the sentiment which twenty years later has been echoed by Dr. Reed in his trenchant plea; but I knew that they could not stand up against the spirit of intolerance which was rooted in the profession, and against the general sentiment that the member who entertained the least faith in the homœopathic principle was a traitor to his profession, and doubly so to his *Alma Mater*.

I finally resigned and joined the homœopathic ranks, where in all these years I have remained, urging my new friends, as I did my old, to bring about such a unification as would join physicians of all schools together under the one ennobling inspiration of "Conservators of the public welfare." By invitations to members of the dominant school to meet me in consultation, and by pleas for amalgamation uttered in my own ranks and among my own societies, I have sought to break down the barriers which separate the schools of medicine, and bring all medical men together for a united effort at "conserving the public welfare."

Did time permit, I could fill your journal with statements of the rebuffs I have received from all sources. The old-school men turned on me, and knifed me whenever and wherever they could. Men whom I knew and loved, with whom and for whom I had labored, men even under whom I had studied, not only refused to consult with me, but failed to observe the very first principles of the moral ethics which should actuate the conduct of the gentleman. Were I to mention the names of certain illustrious men in this city who have widely departed from the ordinary rules of gentlemanly and honorable conduct in return for my manifestations of confidence in their skill and manliness, and relate in detail their actions, it would bring a blush of shame for their profession to the cheek of men like Dr. Reed who see in the practice of medicine something else than the opportunity for an adherence to a so-called ethical law which, far from conserving the public welfare, has often stood as the obstacle to that help in the hour of need which an attendant on the sick, happening to be a homœopathic practitioner, has sought at the hands of the practitioner of the other school of belief. Instances of brutal refusal to consult are but small things compared with the many other instances of which I could tell. Philadelphia is the hot-bed of hate, so far as the dominant school is concerned, toward my branch of the profession. If Dr. Reed, or any other man, can in the short time between now and next June induce the members of the dominant school in this city to believe that the position they have assumed for the past twenty or more years against me and against those who, for the time being, I represent, has been wrong, he will be doing wonders. The spirit of opposition is as deep-rooted here as it ever was—though, it may be, some master-mind may so influence matters as to point out the path of duty, and by gentle persuasion induce a change of heart and action.

When Hahnemann was turned aside and persecuted for his advocacy of a principle he believed to be true, and which he so well defended, the profession courted the very thing which, if they had been wise, they would have known would happen—namely, the formation and final upbuilding of a powerful

organization, with the newly-announced law of cure as its underlying principle. To-day, as a separate school we have such strength that, I take it, the thinkers of the dominant school may well feel we are a rival worthy their steel.

Our medical schools, our hospitals, our literature, our practitioners, our results, are real entities; they stand for much, and I do not wonder that far-seeing men, such as Dr. Reed, looking slightly ahead, see us in the future growing still stronger and more powerful, all the while manifesting more and more our ability to care for ourselves and relying less and less on the skill and knowledge of our brothers of the opposite side. Our self-reliance, our sturdy life, our great prospects, our cohesiveness—all these things are well known to Dr. Reed, and I imagine he does not despise the lessons they teach.

The dominant school has forced the growth of the homœopathic school of medicine to one of large dimensions, and ostracism has simply added to its strength; so it is a question as to whether, now that the prospects are "fair" for amalgamation, the members of the new school will wish to "manifest a desire" to be identified with the movement of reform, without first ascertaining what it implies.

It is altogether probable that before their proposed reform of attitude on the part of the dominant school toward other "schools" than itself ever comes to fruition, the members of these outside branches of the profession will want to consider the subject in all its phases; and, as Dr. Reed says, "the ultimate success of a movement of this kind must come from a demonstration of its desirability." The homœopathic profession has become so accustomed to the treatment accorded it by the other school that for a long time, at least, it is likely to distrust, as not being well meant, any invitation to enter the ranks of those who hitherto have so illy treated them.

Personally, I have for years hoped to see the time arrive when as a legal physician I will have a moral right to the counsel and service of any other legally-authorized practitioner, for the benefit of my patient or to conserve the public welfare.

I fear, though, that it will take more than the proposed action at Saratoga, in June, to effect such a consummation.

However, addresses such as that of Dr. Reed tell the story of what is passing through the hearts and minds of men who, looking above the sordid things of life, and gazing far beyond the narrow limits of a code of ethics which ought long ago to have been buried out of sight, seek only the good of their fellow-man, thus exemplifying that spirit of brotherly love which should actuate the members of the medical profession more than any other body of men.

(Signed)

G. Maxwell Christine, M.D.,

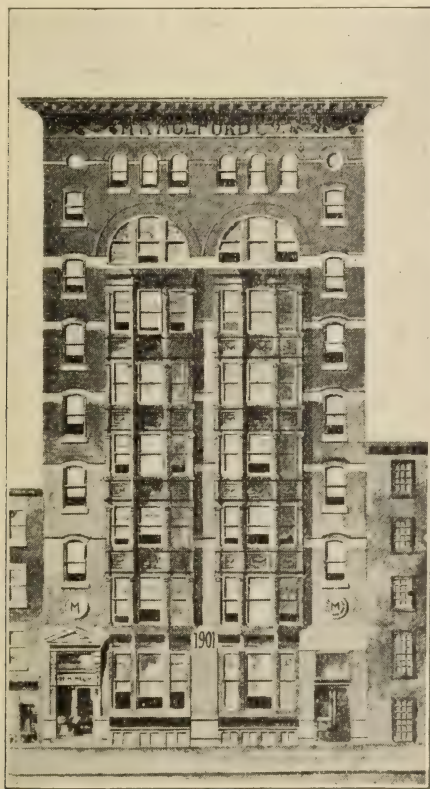
University of Pennsylvania; Hahnemann Medical College, Phila.

H. K. Mulford's New Building.—We have just received one of the new catalogues issued under date of June 20th, by the H. K. Mulford Company, and an examination of the list shows a number of improvements and changes that are of live interest to every physician. The list has been classified so as to enable the physician to readily find his wants; a full and complete table of contents has been arranged, and in addition a therapeutic index has been included for the convenience of those who desire to make reference to the entire list; a copy of this new catalogue should be in the hands of every physician.

In view of the present agitation on the subject of the metric weights and measures, metric dosage on fluid extracts is included. This is in keeping with the requirements made by scientific men for the general introduction of the metric system throughout, and no doubt will be followed out more largely in future lists. A large portion of the catalogue is devoted to listing a number of special products, on which information is given as to the therapeutic action, dosage, etc.

The department devoted to antitoxins and vaccine is not only descriptive of the method of preparing biological products, but also shows half-tone reproductions of the excellent facilities which this firm enjoys for the scientific preparation of these products. Half-tone reproductions are shown of their new laboratories situated at Glenolden, where all the antitoxin, vaccine and various biological work is carried on. It is significant of the closer appreciation of scientific work by manufacturers to note the very excellent equipment which the H. K. Mulford Company have provided for the production of these products.

Their pharmaceutical laboratories have been recently very much increased by the erection of a handsome building in Philadelphia adjoining their old laboratories. (See cut of new building.) This new building is eight stories in height, with two basements, and is equipped with the latest up-to-date electrical de-



VICES, by which the cost of manufacture is brought to the minimum; not only this, but their machinery department has been entirely reconstructed and brought up to the highest state of efficiency.

The growth of this firm, while unusual, is not remarkable when consideration is taken of the energy and efforts that they have made in the line of bringing before the medical and pharmaceutical profession the direct results of scientific research-work in the lines of bacteriology, pharmacology, and physiological chemistry.

Among the newer products which this firm have recently introduced is Somnos, a definite synthetic, formed by the synthesis of chloræthanal alcoholate with a polyatomic alcohol radical. This product is unusual in that it gives prompt sedative and quieting effect, and produces sleep without any untoward action on the heart or general circulation.

Protan is another new synthetic product, formed by the synthesis of tannin with nucleo-proteid. The astringent effects are not imparted to the system until the intestinal tract is reached, where the tannic acid is slowly evolved, and its astringent properties are exerted exclusively upon the entire intestinal tract from the duodenum to the colon. The principal advantages of Protan will be manifested in the treatment of children's diseases peculiar to the summer season.

Arrangements have been made by which the readers of this journal will be able to secure from H. K. Mulford Company, if request is made to Philadelphia, a liberal quantity of Somnos and Protan, sufficient to prove its therapeutic value in a number of cases.

The New Jersey State Homœopathic Medical Society.—The meeting held in Newark, May 3d, elected the following officers for the ensuing year: *President*, Dr. James Franklin Ackerman, Asbury Park, N. J.; *First Vice-President*, Dr. Frank Caulkins Bunn, Orange, N. J.; *Second Vice-President*, Dr. Justice H. Cooley, Plainfield, N. J.; *Third Vice-President*, Dr. Joseph Shreve, Burlington, N. J.; *Recording Secretary*, Dr. Isaac Cooper, Trenton, N. J.; *Corresponding Secretary*, Dr. Wallace McGeorge, Camden, N. J.; *Treasurer*, Dr. Frank Sharpes Carpenter, Newark, N. J.; *Censors*, Dr. Henry Knox Stewart, Dr. Theo. Y. Kinne, Dr. Armin Uebelacker, Dr. Charles Herbert Church, Dr. Oscar L. Grumbrecht.

The following papers were discussed: "Nausea and Vomiting of Pregnancy," by Alfred William Baily, M.D. "Gall-stone Disease: Some Chemical Notes on," by Frank Caulkins Bunn, M.D. "Eye-Strain: Headache from," by William Franklin Beggs, M.D. "Hypertrophied Tubinates," by Edward Hill Baldwin, M.D. "Constipation: *Hydrastis Canadensis*, with Cases," by Wallace McGeorge, M.D. "The Indicated Remedy," by John Kelly Mulholland, M.D. "Pregnancy: a Complicated Case," by Henry Knox Stewart, M.D. "Puerperal Peritonitis: Treatment of," by Clinton Clements Straughn, M.D. "Child Patients, Suggestions in Treatment," by Marietta Huntoon Crane Woodruff, M.D. "Discipline in Early Infancy: The Importance of," by Annie Lowe Geddes, M.D.

The Society has lost three members during the year—Dr. Bowman Hendry Shivers, Haddonfield, N. J., Dr. Anna Eliza Griffith, Camden, N. J., Dr. Harry Frederick Nichols, Hoboken, N. J.—and added ten to its roll of members at its annual meeting.

Medical Unity.—"The Erie County Medical Association has accepted to membership two prominent homœopathic physicians who applied, one of them the Secretary of the New York State Homœopathic Society. These physicians will now be looked upon as regular practitioners."—*American Medicine*, June 7, 1902, p. 940, fourth paragraph.

Putrefactive Processes.—As an antiferment, to correct disorders of digestion, and to counteract the intestinal putrefactive processes in the summer diarrhœas of children, Listerine possesses great advantage over other antiseptics in that it may be administered freely, being non-toxic, non-irritant and non-escharotic; furthermore, its genial compatibility with syrups, elixirs and other standard remedies of the *Materia Medica*, renders it an acceptable and efficient agent in the treatment of diseases produced by the fermentation of food, the decomposition of organic matter, the endo-development of fetid gases, and the presence or attack of low forms of microzoic life.

An interesting pamphlet relating to the treatment of diseases of this character may be had upon application to the manufacturers of Listerine, Lambert Pharmacal Company, Saint Louis.

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SPECIFIC TREATMENTS.

BY WILLIAM C. GOODNO, M.D., PHILADELPHIA.

(Read at the meeting of the Am. Inst. of Homœopathy, held at Cleveland, June 17, 1902.)

WHEN any medicine or method of treatment sufficiently often controls a combination of symptoms or a well-defined form of disease to demand its employment, even if it is closely related homœopathically to the case, rather than the selection of a remedy strictly upon homœopathic indications, it becomes specific medication or specific treatment. This, then, is the sense in which these terms are used upon this occasion.

At the outset, I desire to state that the title of my paper was inspired by one prepared by that excellent clinician, Dr. Andrew H. Smith, and which appeared in the *New York Medical Record* for March 15th, of the current year. As all the treatments referred to in that article were medicinal, and addressed to the exciting causes of disease, it would have been entirely proper had the author entitled his paper "Etiologic Medication."

Limiting myself upon this occasion to the treatment of infectious disease, I will recall that, if pathogenic organisms are introduced into a healthy body (and in parenthesis it may be said that, while health is a relative term, there are, practically, healthy people), a reaction against the intruders is at once developed. In the warfare which is waged between the phagocytic cells and the intruders, the body suffers much irritation and develops many symptoms, and, often, well-marked path-

ologic changes. All that goes wrong in such a body is the result of the injury done by the unwelcome visitors and the strain of the organism in overcoming them. If the development of the bacteria is inhibited and their poisonous products destroyed, health is rapidly restored. Some of these infectious diseases are due to perfectly identified organisms, and for which, in a few instances, we have discovered specific treatments which, when applied at the proper time, and in the proper manner, give highly successful results. The agents employed are of various sorts, or variously combined, so as to strike directly at the cause or causes of all of the numerous symptoms and their underlying pathology. They are not necessarily medicines. Whether it is best to employ such specific methods, or to antagonize the results of the influence of the poison upon the blood and tissues of the body by the devious paths of symptomatic prescribing, is one of the most important questions before the homœopathic profession to-day, and a question which the speaker hopes this paper may call increased attention to.

Of the specific methods of treating infectious disease, serum therapy is best known and has thus far given the most perfect results, although the success achieved by the carbonate of creosote and the salicylate of sodium treatments of pneumonia have thus far been highly satisfactory. The mortality from pneumonia in hospitals, and hospital reports are in general much more reliable, varies from 20 to 30 per cent. Perhaps 25 per cent. represents a reliable average. This probably holds good for the homœopathic as well as for the old-school hospitals. Mortality is rarely as low as 15 per cent. in private practice. It would be impracticable for me, within the limits of a paper one is permitted to read before this body, to bring together the statistics and arguments in favor of this creosote treatment. I can only state that the mortality, estimated from series of cases numbering from a dozen to one hundred or more, has been reduced, as in Sebring's collection, to less than 2 per cent. These cases were nearly all severe in onset, and some of them desperate. An interesting feature of the subject is the uniformity in result as given by various observers in different countries. My personal experience is as yet too small to warrant my presenting in statistical form my results, but thus far they fully confirm the published statements.

Frieser, of Vienna, in a recent article in the *Äerztliche Central-Zeitung*, says of creosote carbonate in the treatment of pneumonia, that the treatment "has yielded entirely satisfactory, and even brilliant results."

Ebersson, in the same periodical, states that it cuts short the disease in a most remarkable manner, causing complete and rapid resolution of the diseased focus, and that the sputa and all excreta are voided disinfected, thus lessening danger to others.

Wilhelm Meitner (*Medicinisch-Chirurgisches Centralblatt*) writes that there is a "surprising fall of temperature a few hours after its administration is begun; it becomes normal in two days or sooner," and that there is a corresponding subsidence of the other symptoms.

Andrew H. Smith, William H. Thompson, Ferguson, Van Zandt, Stokes, Liegel, Sebring, Cassoute and others, have all reported most favorably concerning creosote carbonate as a specific remedy for pneumonia.

The treatment of diphtheria by means of its antitoxin is so certain in its results, and now so generally practiced by all well-informed physicians, that its neglect is horrifying. I have written so much upon this question, and presented, to my mind, such conclusive statistics confirming fully the almost innumerable series from general sources, that I need say no more than to state that I consider the treatment as perfectly specific, *i.e.*, it practically never fails unless its application is too long delayed.

In glandular therapy the success of the thyroid extract treatment of myxœdema is well known. A complete removal of the symptoms is almost certain to follow its administration. The result being made permanent only by the continuous employment of the remedy makes the treatment none the less specific. Other lines of experimentation are promising much.

The suprarenal extract is proving of such value for hæmorrhage that we may think of it as almost a specific, in so far as there can be a specific for this symptom. Since October of last year I have prescribed it for six cases of hæmaturia, all that I have seen, with prompt success in each instance, although the underlying conditions in some of these cases were irremediable.

I have been much impressed by the treatment of scarlet fever with carbolic acid. It was first recommended to me by my old friend Dr. Clay, of Moorestown, N. J., whom some of you may have known as an acute observer. Dr. Wigglesworth, who has published a number of communications upon this subject in English medical journals, claims to have converted scarlatina into a mild disease by means of the administration of full doses of carbolic acid, even to carboloria, in some cases. This agent, along with proper hydrotherapy and the iodohydrargyrate of potassium or sodium for the later symptoms of some cases, furnishes a most successful treatment. The administration of the carbolic acid must be begun early. The danger from this drug has been grossly exaggerated, or impure articles, which is certain, have been much used. With Merck's or some other equally good first quality crystalline acid you need have no fear. Although I have used it most liberally, I have never noticed unpleasant symptoms of any kind. At the risk of verbosity, I repeat that early administration is the most vital point in the treatment, as it is in treating every infection by whatever method. Equally important is it to continue the treatment until the disease is fully controlled. I feel sure that Wigglesworth is correct in his statement that the infection communicated by cases so treated is of slight intensity. He even advocates the exposure of children to this modified scarlatina rather than taking the chances of exposure to a virulent form later. Highly satisfactory as is the homœopathic treatment of scarlatina when compared with general methods, my experience leads me to believe that the carbolic acid method is much superior to all. The dose is from one to five or six grains, according to the age of the patient, every two to four hours. The acid should, of course, be freely diluted with water. Do not give it with alcohol in any form. Some French observers have given as much as several hundred grains of carbolic acid during each twenty-four hours, and insist that a pure acid is practically harmless.

A combination method which we are justified in considering as specific, and which is so well exemplified at Carlsbad, is the treatment of cholelithiasis by means of diet, alkaline waters, etc. Results are governed by the thoroughness with which the treatment is applied. As I have taught and

talked this plan for many years, my opinion is based upon considerable experience, which, however, is infinitesimal compared with that of the Carlsbad physicians. My conclusions respecting it are, first, that the faithful carrying out of the treatment seldom fails to relieve all of the symptoms of the gall-stone disease; and, secondly, that most instances of failure are due to a half-hearted application. In respect to this disease, it must be remembered that the symptoms are almost entirely due to inflammatory and other secondary processes arising from the mechanical irritation of the delicate mucous membrane lining the gall-bladder and the gall-ducts by the calculi, and that, following control of these conditions, the calculi once more become latent. Except in unusual cases they are not discharged, and it must be rare, indeed, that they are disintegrated. In eleven years, during which my records have been complete, I have recorded forty-six cases of cholelithiasis. Of this number five have been operated, nine have been lost sight of after relief in most, and the remainder, with a very few exceptions, have responded perfectly to the treatment under consideration.

About 20 per cent. of these have had recurrences, which have been controlled by a resumption of the treatment. Kehr pertinently remarks, in his recent extraordinary work on the gall-stone disease, that "a persistent latent stage is almost as good as a cure." The essential parts of the treatment are, first, the reduction of the carbohydrate element in the food to the minimum; second, the free use of Carlsbad water (preferably hot, and before meals); third, proper exercise, to increase oxidation, excretion, etc.

The surgeons have been gradually invading the medical man's territory, and with increasingly improving results. It is only necessary to cite appendicitis and gall-stones as examples. Probably the most brilliant of all, however, is the operative procedure recently introduced for the control and cure of Bright's disease. No surgical operation is more positively entitled to rank as a cure for a disease. Although the time since its introduction has been too limited for final judgment, the results, judging from one year's experience, have been most remarkable. My smiles, which were developed when I first began reading Dr. Edebohl's paper upon this subject, must

have changed into a most interested expression before I had proceeded far. His paper appealed to me at once, and most powerfully, as I find it did to others, especially surgeons. Dr. Van Lennep told me that he had observed the development of new blood-vessels extending into the kidney, where the capsule had been incised during previous operations, and that he was anxious to test the method. To this date I have observed the results of the operation in five cases, two of which were performed by Dr. Van Lennep, two by Dr. Chase, and one by Dr. Northrop. The results have been marvelous. One of these patients died forty-eight hours after the operation. The case was an extreme one, and Dr. Van Lennep objected much to operating; but the patient demanded the chance, and we felt forced to give it to him. All of the others have improved brilliantly. These cases will be reported *in extenso* later.

For a variety of conditions characterized especially by asthenia of the nervous apparatus, protracted rest with the employment of various means for the stimulation of metabolism, especially massage, electricity in its various forms, and a proper diet,—in short, the rest-cure,—are, in the absence of organic changes, quite uniformly successful, and deserve consideration among specific treatments. Other specific methods, of various character, might be considered here, but those referred to are sufficient for my purpose. In reference to this method of treatment, I may say, in concluding my consideration of the several forms, that it appears to me as rational to specifically treat an infection as it is to remove poison from the stomach, or to antidote any which remains in the system.

Perhaps no treatment, however much we may be justified in considering it as specific to a given disease, can ever prove perfectly successful in its application. For one reason, the clinical disease and the bacteriological disease may not be identical. As an example, I may cite the case of a young Englishman who was recently received into my service at Hahnemann Hospital suffering from a clinical entity suggesting typhoid fever. After the lapse of one week the temperature came down to about normal, and I felt that I had probably been dealing with an influenza; but after forty-eight hours there was a rather rapid rise of temperature, and the appearance of cough. This rather confirmed my conclusion that the patient had influenza. Three

days later I discovered well-marked consolidation of the right, posterior base. The cough now increased much, and a copious, glutinous, sticky bloody sputum appeared. The quantity of blood was considerable, but little if any of the expectoration presented the distinct "rust" appearance of pneumonic sputum. The respirations reached 36 to 40, but the pulse did not yet exceed 100. The malar regions were flushed, the tongue was coated but not dark or especially dry, the bowels remained constipated, the abdomen was sunken, food was well taken and borne, and there was little complaint. The clinical condition now clearly indicated pneumonia following upon influenza. Three examinations by Dr. Sappington, the hospital pathologist, revealed pneumococci in small numbers; also an undetermined bacillus in large numbers. The blood had been twice tested for the Widal reaction with positive results. Five days after the evidences of pneumonia appeared a violent general pleurisy set in, with rapid effusion of fluid and aggravation of all symptoms. Bacteriological investigation now determined that the unknown bacilli referred to as present in the sputum were the bacillus typhosus. It gave the Widal clumping. After over three weeks of illness the first loose stool appeared, and diarrhoea of a typical character continued until convalescence was established.

This case presents many points of interest, some of which bore strongly upon the question of clinical and bacteriological disease. Some of these are:

1. The suspicion of typhoid in the early stage.
2. The later belief in the influenzic character of the case when the temperature dropped to normal.
3. The well-developed pneumonia later, a few pneumococci being found repeatedly in the sputum, and the complete failure of creosote carbonate at this stage.
4. Development of acute general pleurisy with free liquid effusion.
5. Discovery of the bacillus typhosus in the sputum in large numbers, and the securing of the Widal reaction from the same.
6. The securing of the Widal reaction repeatedly in the ordinary manner.
7. The delay of bowel symptoms until the end of the third week.

8. The absence of the typhoid state except in slight degree near the close of the disease.

The man made an excellent recovery. There can be no doubt but that this was a case of early, and probably primary, development of typhoid fever in the lungs instead of in its usual location in the bowel. Of late we have learned that this is not a very uncommon thing.

It is evident that such a case as this one presents great obstacles to specific treatment from the etiologic standpoint. The rôle of the pneumococcus was uncertain. Possibly its presence was necessary to the development of the pneumonia; that unaided, the bacillus typhosus was unequal to the task. Whether this organism did or did not excite pneumonia I cannot with certainty state, as it is so often found in the secretions of the healthy, but the number present suggested that it was an active factor. If so, its toxin was producing its peculiar toxic symptoms; therefore, even had we an effective antitoxin against typhoid fever, it might not have proven sufficient to control a case of this double character without the simultaneous employment of one for the pneumococcus or other associated pathogenic organisms. An antitoxic drug agent, whose influence is probably for the control of the pneumococcal toxin, proved of no apparent value. Fortunately, most infections are sufficiently pure in the early stage to permit of the successful use of a single antitoxic agent. This is well demonstrated in the antitoxin treatment of diphtheria, the streptococcus frequently demanding attention when treatment has been too long delayed.

There is much misunderstanding respecting "specific treatments." Specific treatment is something more than naming a disease and giving a drug, or applying a method labeled as good for the same. I was greatly impressed, years ago, by reading some fourteen columns of a New York medical journal devoted to a consideration of the bromide treatment of epilepsy by that greatest of American neurologists, Dr. Seguin. It was practically the treatment of one symptom with one drug. Much can be said respecting the details of application of any of the specific methods of treatment. The following are a few things worthy of note:

1. Certainty in diagnosis, *i.e.*, being sure the case is an example of the disease we think it is, and, consequently, that we are applying the proper specific.

2. Determining that the case is seen early enough to secure benefit from the treatment, and, therefore, that it is worth the while to try.

3. Determining that there are no complications or associated disease contra-indications.

4. The proper dose and frequency of repetition of the medicine, antitoxin, etc.

5. Keeping a proper balance between the various parts of a combined method.

6. Securing good drugs, antitoxins, etc.

There is a kind of specific medication practiced according to the homœopathic method which gives admirable results. As indicated, this treatment is suggested by similars, and is addressed in a routine manner to well-defined groups of symptoms and to diseases. I will cite only a few of these. Many years since, the writer called attention to the value of gelsemium as a remedy for the early stage of acute rhinitis. The correctness of the observation has been quite generally confirmed. Given in a good preparation and proper dose, and, above all, as in all specific treatment, sufficiently early, it proves quite as specific a remedy for colds in the head as any specific treatment is for any affection. There is no evidence that gelsemium acts upon bacteria or their toxins, or in any chemical way, but it is none the less a specific treatment. I also advocated the specific influence of colchicine over typical, acute, rheumatic polyarthrititis. This has been abundantly proven, but who will explain how it acts? Who will say why the same drug usually controls the acute, arthritic manifestations of gout? If the homœopathic principle really or apparently explains the action of these and many other medicines in their rôle as specific medicaments, why not accept it until a strictly so-called scientific basis for their action can be advanced?

Many will contend that every homœopathic prescription is specific medication, and, in a sense, this contention is perfectly correct. Many do believe that homœopathy is all-sufficient for the treatment of all symptoms and diseases, under all circumstances, regardless of cause or of other methods of treatment. If true, this must be demonstrated and proof presented. There is still a tendency with a few to contend that homœopathy is a perfect system of therapeutics, and only requires sufficient

knowledge upon the part of the prescriber in order to its successful employment. Viewed from the clinical standpoint, however, homœopathy is not a perfect system of therapeutics. It is impossible that any system, in its practical application, can be. Either from inherent weakness of the system or ignorance, we at times fall short in its application, and must then seek the help of accessory methods. If, as some say, this happens seldom to them, still it does happen, and must occur in the practice of every man who is sufficiently educated to know something of the limitations of curative medicine. The over-weening confidence displayed by so many is due to lack of careful clinical investigation, and, equally important, the recording of it. The failure to recognize the limitations of homœopathy constitutes a grave error, and one which, more than any other, will justify the position of the old school concerning us. The aim of the great body of physicians to-day, aside from an enlightened class of generous and progressive gentlemen, too few in every profession, is to force us to the exclusive practice of homœopathic therapeutics under all circumstances. However seldom one may find it necessary to depart from its employment, we must insist upon our full right to the entire domain of therapeutics, and to stand upon the same plane as the inappropriately self-styled "regular." The claims of many homœopathists in the past, but of a very small percentage to-day, have fully justified the dominant school in this demand; but representing, as I believe I do, the feeling of the great body of the homœopathic school, I insist upon our full right to all of therapeutics. If one does not weigh words carefully, and this is difficult in following a rapidly read paper, it is easy to unintentionally distort statements and misconstrue the speaker's meaning. This is doubly apt to occur if statements are made which run counter to our established lines of thought, and our prejudices are aroused. I have some sympathy with the sensitiveness of many, especially of the older members of the profession, who are "thin-skinned" upon this subject of criticism of homœopathy and homœopathists. Even I am sufficiently old in the practice of medicine to remember well the earnest opposition it was necessary to present to the arrogance and oppressive tendency of the old school; and I confess that, in view of this fact, it is an effort for me to occupy a perfectly

judicial position regarding existing medical and ethical questions. Our services to medicine, if they were only of a negative character, demand for us full respect and professional courtesy. I believe we, as a body, are searching for truth as earnestly, and doing our work, as we understand it, as faithfully as our old-school brethren; and I am sure that, while most of us believe that homœopathy was nearly the beginning, it will not prove the end of therapeutics. Valuable as have been the advances made in general therapeutics during the last quarter of a century, homœopathy is to-day the only method at all generally applicable to disease; and we believe it is only here and there as yet put out of action, and then by great mines laid beneath the enemy's works.

Let us not claim too much, but remember that homœopathy developed in the beginning of the scientific era in medicine as a reaction against the excessive and unwise medication of the time, and that the great results immediately attained were in a measure apparent only, and that they have been employed too much for their face value ever since. The true student of medicine has, however, very properly discounted them, and endeavored to eliminate the percentage related to the cessation of injurious methods. My own observation impresses me that, after I have accomplished this, homœopathy is in its results still an exceedingly satisfactory method of treatment, except in a few instances, some of which have been referred to. To deny the possibility of some recent methods being possibly more successful than homœopathic medication is to relegate therapeutics to the position of being the only branch of medicine in which advance is impossible. Had Hahnemann lived until our day, I doubt not that with his progressive and scientific mind he would look with contempt upon some of us little fellows, who have spent most of our time worshipping at his shrine.

As to the future of homœopathy, in which we are all so much interested, I feel that the time has arrived when we must demonstrate its positive and relative value, if we hope for it to retain even its present position. This can only be accomplished, in my humble opinion, by demonstrating what it can do for diseases. In the past, clinical reports have dealt too much with individual cases and groups of symptoms not having

a defined pathological character. Strange to say, there are few reports to be found in our literature embracing any considerable number of cases of a single disease. If you were asked as to the success attending the homœopathic treatment of pneumonia, from what sources would you draw your evidence? For Dr. Smith to state that he has "never lost a case," or for Dr. Jones to say that he thinks his mortality is about such or such a per cent., does not satisfy scientific inquiry. Had we not better be up and doing in the matter of developing satisfactory evidence? Personally, the writer has had a staff working for some time upon the statistics of Hahnemann Hospital of Philadelphia, and hopes to soon present considerable statistical material. I call upon all of you gentlemen who are hospital physicians to stimulate your colleagues to unite with you in the same work.

In concluding this paper, allow me to suggest that in debating it we endeavor to remember that one's belief is not proof, that glittering generalities prove nothing but ignorance, that mere statements of "superiority" are as "sounding brass and a tinkling cymbal."

MECKEL'S DIVERTICULUM AS A SURGICAL FACTOR.

BY O. S. RUNNELS, A.M., M.D., INDIANAPOLIS, IND.

(Read before the Surg. and Gyn. Soc. of the Am. Inst. of Hom., June 17, 1902.)

MECKEL'S diverticulum is a vestige of embryonic life, and is found in about 2 per cent. of the population. Being thus absent in 98 out of every 100 adult people, it follows that it is not a vital part in mature life. Inasmuch as it serves no physiological end in post-natal life, we could pass it with mere mention, if that were all, as a superfluous appendage, or, otherwise, only as another instance of innocent anatomical variation, like the sesamoid bones, the web-foot, or the sixth digit.

But not so; for thereto hangs a tale—a recital of interference and difficulty that very often reaches proportions of the first magnitude. It is a question possessed of gravity vastly greater than the percentage of its frequency would indicate, for no proofs of its presence may be found before the advent of the difficulty it

may cause, and no diagnostician can be certain of its presence after that advent until an exploratory abdominal operation reveals it. There is no way to determine the presence of Meckel's diverticulum in the average case without intra-abdominal exploration. No one can determine before surgical intervention whether or not he is to be confronted by the one case of the kind in an average of every fifty persons.

It goes without saying, therefore, that this useless and comparatively rare piece of anatomy is a very important thing to know about and to remember. Especially is this momentous to the surgeon, since it may add to any abdominal exploration the most serious complications and operative difficulties known to surgery, and since every abdominal operation must be undertaken with the chance of its presence.

This anomaly, first recognized by Lavater, called a diverticulum by Ruysch, and differentiated by John Frederick Meckel, is an offshoot from the small intestine, or rather a bifurcation of that bowel with one of the canals closed a short distance further on, making a *cul-de-sac* or pouch similar to the cæcum, as is proved by the identity of the walls and the presence of Peyer's patches. It is really another instance of appendix; but, unlike its vermiform fellow—also a vestige—it has usually the same calibre as the intestine, and has ordinarily a patulous lumen. For this reason it does not become choked or sealed at its proximal end by inflammatory process or as a result of embarrassed nutrition. While its usual site is upon the ileum, from twelve to thirty-six inches from the ileo-cæcal junction, it may be found anywhere upon the small intestine. It is rare, however, upon the jejunum, and rarer still upon the duodenum.

Its histogenesis is interesting, inasmuch as it plays its useful part in very early embryonic formation, and has served its day by the end of the sixth week of utero-gestation. After that time it has no office and nature is solicitous for its removal. This elimination is almost always successfully accomplished; but failure results two or three times in a hundred, and the surgeon or anatomist occasionally finds it out.

Meckel's diverticulum is the remnant of the yolk-membrane of the original ovum. The human ovum, as well as all meroblastic ova—*i. e.*, the ova of all mammals, birds, reptiles, and most of the invertebrates—is composed of two yolks: the

germ-yolk or central nucleus and the food-yolk or vaster portion. The office of the first is germination, cell-cleavage and development of body; the office of the second is food-supply or nutriment-store merely, and no cell-formation ever occurs within its substance. One is known as the vitellus-formitavus, the other as the vitellus-nutrivus.

The mysterious process of cell-cleavage immediately following the impregnation of the germ-yolk progresses rapidly during the first few days to the formation of what is called the gastrula, germ-cup or primitive stomach. The segmentation of cells has gone forward so rapidly as to show very shortly an invagination to the growth or an intimation of nature's purpose to have an inside and an outside for the creation in progress. The walls of the vitellus-nutrivus or larger yolk-chamber are thus utilized in the evolution of the stomach and intestines of the embryo. The connection of this embryonic intestine with the placenta is direct and unimpeded. It is called the vitelline duct. Early in the second month the closure of the plates forming the abdominal wall divides this duct or canal at the umbilicus into two portions—into an extra-abdominal segment and into an intra-abdominal segment. They both atrophy as soon as the placental circulation is established, and either wholly disappear or remain as vestiges. The extra-abdominal segment is found as a mere string or piece of catgut lying in Wharton's jelly in the umbilical cord, while the intra-abdominal segment, passing most frequently from the ileum to the umbilicus, sometimes remains either as an open canal—an umbilical fistula—or as a mere cord, like its other part in Wharton's jelly. Usually it disappears entirely, leaving no trace. Again, it may atrophy only in part, leaving a pouch-like appendage upon the bowel, with or without its cord-like portion continuing as a prolongation from its extremity. In case the cord is present, it may have attachment or adhesion at the umbilicus. Yet again, the corded portion may have disappeared at the umbilical end and be found projecting from the terminus of the diverticulum for several inches, with a free extremity. This may float freely in the abdomen, but usually attaches itself to a bowel-loop or to the adjacent parietal wall. Occasionally the diverticulum is provided with a mesentery and large nutrient vessels.

The embarrassments to normal life-exercise occasioned by Meckel's diverticulum are many. First in order is the instance of the non-closure of the vitelline duct at the umbilicus, when the cleavage was made by the closure of the plates forming the abdominal wall. A patulous canal is thus left from the intestine through the umbilical gateway, which, continuing within the funis, may extend to the placenta itself. In such cases, the division of the funis at birth and the rejection of its shriveled and cicatricial remains a few days later may leave an anus—*secundum naturam*—at the navel. Sometimes the ligature applied by the obstetrician produces a closure of the canal, which, after the rejection of the funis-stump, may still be in evidence as a small hernial projection from the umbilical orifice. This can be recognized by its pinkish appearance and closer resemblance to serous membrane than to ordinary integument. It follows, therefore, that no umbilical cord should ever be tied or cut without thought of this possibility, and no smallest projection at the navel after the going of the funis-remains in the first week of child-life should ever be snipped off or tied off without realizing that it may be an example of non-atrophied vitelline duct. I am satisfied that many navels of the new-born have this duct with a sealed end as a very intimate neighbor; that many cases of umbilical hernia in young lives are in reality but subcutaneous bulgings of this character, and that forethought and caution in this regard should be exercised by the accoucheur or physician at all times. In many such cases of belated obliteration of the vitelline duct the closure is doubtless effected by gradual atrophy during infantile life, so that instances of Meckel's diverticulum are probably much more common among infants than among adults.

The surgery called for in a case of vitelline fistula or umbilical anus must be regardful of the rigid rules operative in the technique of intestinal surgery, inasmuch as the fistula has intestinal communication, and is, in fact, but the open end of an intestine. The major difficulties incident to Meckel's diverticulum in mature life are occasioned by its aptitude for strangulation. With its corded appendage fastened to a bowel-loop or to the parietal wall, restraint is placed upon peristalsis; the vermicular intestinal motion is embarrassed; and, like a snake tethered at its middle, the squirming and coiling and re-

coiling around the fixation-point is vigorous and prolonged. To make the situation more productive of calamitous possibility, the adhesion of the distal end of the cord to a neighboring bowel-loop or the abdominal wall has made a hoop or ring through which the bowel-loops, in their mad purpose to free themselves, may be driven until the foramenal passage becomes choked. When bowel-loops are thus halted the drawing begins; there is a contraction of the encircling band, and the greater the peristaltic effort to gain freedom the more rapidly and fatefully the cordon is drawn. Very soon the strangulation is complete, and the death of the member or members involved assured. Strangulation from this cause is believed to more than equal all the other strangulations by adhesive bands combined.

Again, the diverticulum may be the sole occupant of a hernial sac, its free extremity having slipped through the ring and become incarcerated, in which case the symptomatology will be very misleading. While the localized pain and hernial protrusion may clearly indicate the nature of the difficulty, the unimpeded current of the alimentary canal will contradict the theory of intestinal strangulation, and the golden moment for obviating necrosis of the bowel is lost.

Cases of invagination or intussusception of the diverticulum have been found post-mortem. The fundus had been inverted or driven into its own lumen, and the circular muscular fibres contracting, as in ordinary cases of the kind, had produced veritable strangulation, ending in death. Here, too, there was no occlusion of the bowels, and the diagnostician was wholly at sea.

Again, residual faecal matter may lodge and bake in the diverticulum, and become so adherent to the mucous membrane as to drag the latter after it when the defecation of the diverticulum is effected. In this case the mucous membrane, separated from the middle and peritoneal coats, is swept into the lumen of the intestine, and serves to blockade and obstruct the bowels.

Foreign bodies may lodge in the diverticulum and set up inflammation and ulceration, leading to perforation and fatal peritonitis. The diverticulum, further, is not exempt from typhoid ulceration and all that that implies.

In several respects the embarrassments of the diverticulum of Meckel resemble those of the vermiform appendix. It may have the digestive disturbances and many of the characteristics of appendiceal difficulty; and, having location not far at any time from McBurney's point, it is well calculated to confuse the observer. These, briefly, are some of the embarrassments of Meckel's diverticulum on its own account. But the situation grows more complex when other problems of that environment are up for solution also.

The storm-centre of the abdomen is bounded by a line drawn from the umbilicus to the right tenth rib, to the anterior superior spinous process of the ilium, along Poupart's ligament to the pubic cartilage, and thence by the linea alba to the umbilicus. Within this area is to be found more than ninety per cent. of the abdominal emergencies that confront the surgeon. On this account it justly may be denominated the cyclone belt, the volcanic area, or the mine of difficulty; for here we have most of the terrific expressions of retrograde metamorphosis that carry the subject beyond rescue in a very brief time, and that may encroach upon him so insidiously and inexplicably as to deceive and baffle the very elect. This is the region labeled "Surgery; medical men, beware!" for here are the physical difficulties that demand explorations for diagnosis and surgical interventions for cure. The physician who employs expectant measures in this quarter of the human anatomy must be sure of his ground if he would defend himself successfully against the charge of manslaughter. And ignorance of the true condition in this day is no defence. Here it is, so often, that light from heaven must shine directly upon the problem, or there can be no illumination. Here it is that open explorations and manual interventions are so frequently the only possible measures of life-saving.

The following are some of the things that look very much alike to the blind man, or to the one who stands guessing on the outside: Meckel's diverticulum, strangulated, perforated, intussuscepted or necrosed; adhesive bands; intussusceptions, of which more than fifty per cent. are ileo-caecal or ileo-colic; volvulus, or any kind of intestinal kinking, or twisting, or knotting, including obstruction of bowel-lumen by gall-stones, grape-seeds, enteroliths, or prolapsed mucous mem-

brane of diverticulum; hernias, patent or concealed; the appendix vermiformis, strangulated, perforated or necrosed; localized or generalized peritonitis; ileo-cæcal cancer; elongated gall-bladder, distended with stones or serving as a pus-centre because of its perforation or rupture; floating kidney; ovarian tumor, with twisted pedicle; appendix attachment to degenerate ovary or diseased Fallopian tube; right side ectopic pregnancy, with or without rupture; as well as any of the degenerations, carcinomatous, sarcomatous or benign, that may occur in this storm centre, as well as elsewhere in the body.

The question always first pressing for answer is, What is it? The reply would be simplified somewhat if but one of these conditions could be operative at a time; but of this there can never be any certainty. Frequently, as we know, two or more of them often join in making "confusion worse confounded."

With such possibilities confronting the physician, what can be said in favor of the employment of an anti-phlogistine plaster over the abdomen; or of medications, either internal or external; or of any other form of expectant treatment for days or weeks, while the hapless victim goes on to his doom? What defence can be offered in the courts of God and man for neglect to determine by an exploratory operation the exact cause of the difficulty in the first twelve or thirty-six hours, and to extend the only help possible in so large a percentage of such cases by the employment of manual intervention?

I have been at pains to point out the significance of Meckel's diverticulum in particular, in order that I might show its very general bearing on all abdominal disputation, and to indicate more clearly the differentiation necessary in order to arrive at correct conclusions.

It is a great point gained in the diagnosis of certain emergency abdominal difficulties when the diagnostician has acquired the fact that he can know nothing whatever about some of these things without an exploratory operation, and that the equation of ignorance is the most fatal part of the abdominal problem to-day.

I will cite a single instance as an illustration that occurred in my service at Camp Mount Military Hospital while Surgeon General of Indiana. A man thirty-five years old had been a malingerer all his life. At no time had he ever confessed

that he was well and able to do his share of worldly duty. He was denominated a "shirk," and had thus lost the sympathy and respect of his fellows. In the army his comrades had made him the butt of ridicule; and thus, under taunt and jeer, his days had been passed. He had always been a dyspeptic, and had had frequent attacks of acute indigestion. Often these "sick spells" were accompanied by severe colic-like pains, and much of the time he had had diarrhœa. After two weeks of the usual diarrhœa, and "rheumatism," and "threatened pneumonia," and other complaints, real and imagined, the diarrhœa was suddenly checked, and he could get no bowel-passage. All efforts of his attendants toward this end had been futile for two days, when I was called in consultation at 10 P. M. Both the pulse and the temperature were and had been in the neighborhood of 100; the vomitus was dark-green and blackish, with fecal odor; the abdomen was distended with gas to the utmost, and was generally sensitive. There were no outlines in the picture presented, and diagnosis was mere conjecture. There was physical embarrassment, and the bowels would not move—that was all.

I declared an emergency, and two hours later was looking through an abdominal window. Bowel-loops, black and inflated to the utmost, choked the vision, and it was with difficulty that I could find head or tail. It was an intestinal mass or sheaf, tied by a ligature as large and strong as a clothes-line. This proved to be a Meckel's diverticulum, fifteen inches from the ileo-colic junction, with pouch four inches long, and an adhesive band from its extremity attached to the parietal wall near the colonic mesentery. The bowel-loops had pushed both ways through the foramen thus formed, and had been caught by the tightening. The cæcum also was a victim, and all of the included bowel-loops were of necrotic appearance. The division of the band was opportune. Capillary circulation in the almost sphacelated tissues was re-established after long pouring of hot normal salt solution. Enterotomy was performed by the removal of the Meckel's diverticulum at its base; the appendix vermiformis, fully necrosed and sausage-like, about to rupture, was removed, and the battle was won. He made a fine recovery, soon became fat and strong, and walked erect among men, commanding their respect by willingly doing his share.

EMPYEMA IN CHILDREN.

BY WILLIAM W. VAN BAUN, M.D., PHILADELPHIA.

(Read before the American Institute of Homoeopathy, Cleveland, Ohio, June 19, 1902.)

IN considering empyema it will be well to emphasize the well-known, but at times overlooked, fact that every case of purulent effusion has been at some time, for a longer or shorter period, a case of acute pleurisy, for it is never an entirely distinct affection arising *de novo*.

An inflammation of the pleura may occur as a primary affection, or it may be secondary to some general or local disorder, and the constitution and previous health of a child will exert a marked influence in the line of resistance to the effect of a chill or infection. The presence of a tubercular tendency or heredity, particularly of the lungs, will predispose to pleurisy, while a pleurisy appearing in previously healthy children suggests a possible tubercular origin. In pleurisy, as in all inflammatory conditions in children, there seems to be a special tendency to suppuration. Acute purulent pleurisy of tubercular origin, however, is rarely met with, and a purulent pleurisy, even in a tubercular child, is not necessarily of tubercular origin, as it may be either streptococcal or pneumococcal. Many of the protracted cases are due to tuberculosis, and the possible presence of tubercle bacilli must be borne in mind in estimating the future of the patient.

Empyema in children is much more common than serous effusion, and the younger the child the greater the likelihood that the effusion is purulent. It is an acute infection following the acute infectious diseases, tonsillitis, chronic gastric catarrh, mediastinal abscesses, etc. It is relatively much more frequent than in adults, and is more fatal. As a rule, the whole pleura is involved, encysted empyemas in infants and young children being rare. It is usually unilateral, but it frequently affects both pleura—the part involved corresponding with the lower lobe of the lung. In children with pneumonias which do not resolve promptly, with the auscultatory sounds becoming distant, empyema is to be looked for.

Etiology.—The great majority of cases of empyema in children, especially in those under five years of age, occur with or following pneumonia. Recent bacteriological research with pleural effusions has done much to clear up the etiology of the question, and has led to the following classification of the different varieties:

1. *Pneumococcus* pleurisy.
2. *Streptococcus* pleurisy.
3. *Saprogenic* pleurisy.
4. *Tubercular* pleurisy.
5. *Staphylococcus* pleurisy.

Practically, we can reduce these to three types of cases: 1st, those containing the pneumococcus. This class includes by far the larger number of cases of empyema occurring in childhood, nearly or quite 60 per cent. 2d, those containing the pyogenic germs, particularly the streptococcus and staphylococcus, which are found either alone or more than usually associated with pneumococcus. They are found alone with the pleurisies following rupture of abscesses into the pleural cavity, and in anæmia. 3d, cases due to tuberculosis. These are rare in early childhood, but become more frequent after the seventh year. The presence of the tubercle bacillus is difficult to demonstrate, and the possible tubercular nature of the pleurisy may be overlooked, even in a hasty post-mortem, for inflammatory exudate may mask the presence of an acute miliary tuberculosis of the serous membrane, and the observer may neglect to examine closely the condition of the inter-lobar fissures, the exposed surfaces of which usually become agglutinated at an early period of the disease, and on separating, if tubercles are present, each granulation will appear distinct and clear-cut as when first formed, as no deposit of exudate has been able to collect over them (Fowler.) In this connection it is interesting to note that the exudate of the variety due to pneumococcus is thick and creamy, considerable in quantity, and compresses the lungs, but there is very little thickening of the pleura. That associated with or due to the streptococcus or staphylococcus is thinner, less in quantity, and the pleura is thick, while that of tubercular origin, found in protracted cases, is scanty, and there is considerable thickening of the pleura.

The exudate in infants and children has the appearance of

pus, thick, creamy, and odorless. In some instances it consists of a cloudy serum, which investigation will show to be purulent. The quantity, while it may be enormous, is usually remarkably small, even in fatal cases—not more than seven or eight ounces. Sacculation is much more frequent than in adults, and encapsulation of the fluid is most apt to occur between the lobes of the lung.

Symptoms.—There are no pathognomonic symptoms of empyema. The symptoms of the primary disease usually predominate, and a persistent elevated temperature and rapid pulse after pneumonia is strongly suggestive of empyema. Sometimes pneumonia and empyema are concurrent, and give rise to a series of grave symptoms. Again, a pneumonia, or other infectious condition, followed by exhausting sweats, with a distinctly intermittent temperature and an increasing frequency of respiration, points strongly to the existence of a suppurative pleurisy.

Chills are absent in a large number of cases, the initial symptom being vomiting, headache, or convulsions. Pulsation of pleural effusion is rare, and its presence is limited to left-sided empyemata. Edema of the affected side is seldom met with, unless in old standing cases, yet it is much more apt to occur in children than in adults. It may be present in very acute septic cases. In protracted cases there may be extreme emaciation, profuse perspiration, repeated rigors, febrile urine, increasing anæmia, sallow complexion, annoying cough, with rapid respiration, pointing, rupture of the sac, or, very rarely, absorption in some pneumococcus cases. So the symptom group is not distinctive.

The *course* and *termination* are variable. An effusion may continue to increase in quantity from five to fifteen days; then the inflammatory process ceases and absorption starts in. Absorption rarely takes place during the continuance of considerable fever, and the presence of pus prolongs the duration of the illness. The nature of the effusion and the degree of the thickening of the visceral layer of the pleura are the chief factors determining the re-expansion of the lungs.

The result is hard to estimate, for even after an effusion has been purulent for six months or more, complete re-expansion may take place, following a paracentesis.

Diagnosis.—The signs of fluid in the chest of a child are different from those found in an adult, and the greater the effusion the more difficult the diagnosis, for the pleural cavity may be filled with fluid, and the voice and respiratory murmur may be only slightly diminished, both anteriorly and posteriorly. Again, in partially filled pleura cavities the respiratory sounds are supposed to be weak or absent below the level of the fluid, but in many a child tubular breathing will be audible over the whole dull area, and is frequently a source of error.

In certain localities the diagnosis of fluid must be made with reserve. The presence of fluid admitted, the differentiation of pus and serum becomes a serious problem. The necessity of determining beforehand the character of the fluid present is apparent, for if it is not pus, interference surgically is not necessary, unless the accumulation of the fluid is rapid and excessive, giving rise to distressing dyspnoea, marked cyanosis, great cardiac displacement and aggravated associate symptoms, such as harassing cough, intense intercostal pain, exhausting sweats, rapid emaciation, etc.—which is seldom the case in childhood. Otherwise the serous effusion will take care of itself; and, should it be of tubercular origin, conservative treatment demands that interference should be postponed as long as possible, for removal of the fluid seems to be hurtful to the case. Pus being present, surgery is in order. In all cases the presence and character of the fluid should be positively demonstrated by an exploratory puncture—done with the patient in the upright position. If no fluid is obtained at the first attempt, and the symptoms continue unabated, another exploratory puncture should be made.

The *fluoroscope* is now claimed to give even more positive results than puncture, the picture being especially characteristic of empyema when pulsation of the fluid is visible on shaking the patient.

The *prognosis* is, as rule, favorable, especially when an early diagnosis has been made, and approved methods of treatment have been instituted.

Treatment.—The inflammatory remedies are called for in the beginning, and pus remedies later on. It is dangerous to allow empyema in children to run on to a spontaneous opening, for, practically, recovery never takes place under such circum-

stances ; in fact, death often occurs before pointing has made a bad surgical operation. The moment the presence of pus is established the case becomes a surgical one, and should be so handled, and the old surgical axiom holds good : In the presence of pus, let it out.

Aspiration or operation must now be selected ; and in making a decision it must be borne in mind that aspiration is not always trivial in its results, death having been reported in some instances. If the case is not urgent, aspiration may be employed, provided radical operative measures are not delayed too long, if the progress of patient does not prove satisfactory. In very young children, simple puncture may be followed by prompt recovery by absorption, even if only a comparatively small amount of fluid is removed. The average case, however, calls for operation. An empyema should not be permitted to continue until it causes compression of the lungs, for their tendency is to become encysted.

Operation.—The ordinary operation is to excise under anæsthesia about an inch and a half of the eighth rib in the posterior axillary line. The pus and coagula are allowed to escape, and then a large absorbent dressing is applied. In protracted cases portions of the chest wall are removed according to the methods of Estlander and Schede. In some instances a portion of the thickened pleura has been stripped from the lung, in order to allow a better expansion, the advantages of this being less deformity and a hastened convalescence. It is to be remembered that dangerously profuse hæmorrhages have occurred on incising a thickened pleura. The complication most to be feared medically after an operation is a broncho-pneumonia, which may be due either to a dormant condition at the time of operation now asserting itself, or to a direct infection.

Expansion is a question of vital importance. Some surgeons advocate that the anæsthesia should be stopped on exposing the pleura, and the finger used to break up any recent adhesions. The lung then expands, and the child, wakening, cries or coughs, and so assists in a remarkable manner in the expansion of the affected lung. Old adhesions are obdurate and require the more radical interference of an Estlander operation.

The patient should be encouraged to sit up as soon as possi-

ble, and expansion favored by forcing air from the sound lung into the diseased one. This occurs on coughing, and if the patient will take a deep breath, and try to make a forcible expiration while holding the nostrils with the mouth closed, the dilating effect will be greatly increased. The value of this method is, it requires no instrument and can be done frequently every day. The expansion may also be favored by having the child blow through a tube, forcing water from one bottle to another. It is claimed that expansion is increased materially by the use of a rubber valve over the opening made in the chest. The former practice of freely irrigating the pleural cavity is to be condemned, because it serves to break up adhesions now desired after operation, and it does not seem to shorten the period of recovery, and, if repeated frequently, may result in permanent fistula.

ON THE LIMITED USEFULNESS OF INTRAVENOUS SALINE INFUSION FOR HÆMORRHAGE AND SHOCK.

BY SIDNEY F. WILCOX, M.D., NEW YORK.

(Read before the Surgical and Gynæcological Society of Am. Inst. of Hom., June 17, 1902.)

THIS method of treatment for hæmorrhage or shock has become so universally adopted in the past few years, and has received the approval of so many distinguished surgeons all over the world, that it seems almost a sacrilege to question its efficacy. When one attempts to unsettle faith in an approved practice or theory, he should at least have something else to put in its place, if the grounds for his heresy are well taken; and perhaps I may be able to set forth a method which may prove to be better in its results.

Without entering into a discussion as to the relative value of the saline infusions as compared with the transfusion of blood, I will confine my remarks entirely to the former, the latter having been demonstrated to be attended not only with danger to the patient, but often impracticable. Intravenous saline infusion has been practiced for about fourteen years, and the credit for the first suggestion is given by Dr. Herbert R.

Spencer to Golz, Kronecher and Lauder, while Spencer claims to have had the first successful case of saline infusion for post-partum hæmorrhage in April, 1888.*

The salt solution ordinarily employed is approximately a $\frac{6}{100}$ per cent. solution of common salt in sterilized water; with different writers the proportion varies from $\frac{3}{4}$ of 1 per cent. to $\frac{7}{100}$ of 1 per cent.

Lauder proposed the addition of from 3 per cent. to 5 per cent. of sugar to the alkaline $\frac{7}{100}$ per cent. of salt solution, because it makes a more nutritive solution.† It facilitates the taking up of parenchymatous fluid, and is less likely to injure the blood-corpuscles than is the pure salt solution. However, whatever modification of the saline solution is employed makes very little difference. The object is not so much to add a nutritive fluid to the depleted system as to add something which will fill the arteries, and which at the same time is unirritating. When the patient has lost a large amount of blood he suffers from acute anæmia. This condition manifests itself principally by pallor, cold sweat, weak pulse, shallow respiration; and if the patient is conscious, he is restless and anxious. A patient suffering from shock, whether accompanied by hæmorrhage or not, suffers from much the same symptoms; and shock has been defined as "an acute anæmia." When a patient is suffering from shock there is a sudden loss of tone of the vaso-motor system, especially of the abdominal viscera, and every one who has done much abdominal work has noticed the sudden influx of blood into the vessels of the abdomen, and the intense congestion of the viscera, while the patient showed the symptoms already mentioned. With similar symptoms, similar physical symptoms ensue, and there is no doubt that the patient suffering from hæmorrhage has a similar paralysis of the vaso-motor system, and that the abdominal vaso-constrictors in particular lose their power, and the blood left in the system goes largely to the abdomen, while the rest of the body suffers from the lack of the life fluid. The theory of the saline infusion is that, the vessels being sparsely filled with blood, the blood-pressure is greatly reduced, and the arteries have little to contract upon, and the heart loses the stimulation which

* See note, p. 105, vol. i., Jacobson's and Steward's "Operative Surgery."

† Tillman's "Text-Book of Surgery," vol. i., p. 494.

comes from the quantity of blood, and that this must be made up by the introduction of another fluid which will act mechanically, if not affording nutrition.

Now let us look into the facts, and see what happens in a case of hæmorrhage, leaving out of the question altogether any other condition for which saline infusion may be required. Hæmorrhage may occur from one large vessel, or from a number of small ones; and in order to illustrate what I mean, I will cite two cases.

CASE I.—A young married woman, about 32 years of age, was suffering from a deeply indurated, sloughing carcinoma of the left groin. It was a recurrent growth, and had previously been operated on by other surgeons. On February 13, 1897, I was able to remove the growth, but found the femoral vein thrombosed and hard; and I resected about six inches of its length, and brought the flaps of the wound into as good apposition as possible, but had to leave quite a portion to heal by granulation. The case progressed fairly well, and I became hopeful of a good result; but on the night of the 19th I was summoned in haste to the hospital, and found that the femoral artery had broken down and the patient had suffered a tremendous loss of blood. By the time I reached the hospital the house surgeon had removed the patient to the operating-room, and attempted to place a ligature around the vessel, but its walls were so friable that the ligature would cut through. However, he managed to control the bleeding by pressure until I reached the hospital, and I was able to tie the artery with a fillet of iodoform gauze. By this time the patient's condition was perilous, and it did not seem possible that she could recover from the shock and hæmorrhage; and it was more as a perfunctory measure than with any hope of doing much good that I injected three pints of hot saline solution into the median vein. To our surprise and gratification she reacted at once, and thirty-six hours later was in such good condition that I was again able to anæsthetize her and ligate the external iliac artery. She lived until March 1st, when she died from gangrene of the lower extremity. Now, it must be admitted without a doubt that this patient's life was saved for the time by the intravenous infusion of the saline solution; but it must be remembered at the same time that this was a case where only

one vessel was implicated, and that one had been securely tied. From a number of other cases I select

CASE II.—A woman about 60 years of age, suffering from a broken thigh, resulting from osteomalacia. I was called to see her without previous examination, and to be prepared to operate. Not clearly understanding the nature of the case, my preparation was not exactly what it should have been, and a little make-shifting was required for the operation, which was an amputation of the thigh in the middle third. An Esmarch band could not be used, and the femoral was compressed by a pad held in position with strong strips of adhesive plaster, which acted like a tourniquet. The hæmorrhage was not more than would ordinarily occur, but the patient suffered profoundly from shock. After tying the femoral and one or two smaller vessels, the stump was quite dry; but after closing the wound, I thought best to give an infusion of saline into the median vein, which soon restored the strength of the heart's action, and I left the patient apparently in very good condition. In about three hours a recurrence of the shock occurred, and in spite of a second infusion the patient died. On examination of the dressing, it was found that a large clot had collected, and in spite of the dry stump which I had left, she had bled profusely.

A number of other cases have occurred, either in my own practice or under my observation, and I am obliged to own that, with the exception of Case I., I have never seen a case of severe hæmorrhage where the patient was saved by intravenous saline infusion.

Now let us come to the reasons: In Case I. the hæmorrhage was entirely from one vessel—the ruptured femoral artery. When that was secured there could be no more bleeding, however great the blood-pressure. In the other cases, only one or a few large vessels could be found to tie, the heart's action being so weak that a temporary thrombosis occurred in the smaller vessel; but after the infusion, which strengthened the heart's action and increased the arterial tension nearly or quite to the normal, these vessels opened, and hæmorrhage was profuse. A short time ago I happened to go into the operating-room of one of our hospitals where one of my colleagues was laboring desperately over a most complicated case of uterine

myofibroma, in which the bleeding had been profuse. As I approached the patient, I noticed that her condition was alarming, which the careless anæsthesist had failed to realize. I offered to infuse the saline solution, and my offer was gladly accepted. With the injection the patient's condition improved; but with the improvement the bleeding increased, and the only thing which could be done was to apply a lot of clamps and forceps and leave them in place. This controlled the hæmorrhage, and we left the patient on the table in what seemed to be fairly good condition, with dry, warm skin, full respiration and pulse. Shortly afterwards she again failed rapidly, and in spite of everything that could be done she died, but without further hæmorrhage. These cases show a danger which may result from strengthening the heart's action by the saline solution. The increased force simply drives the blood out of the unsecured vessels; but even if the vessels are secured and the outflow of blood stopped, and although the patient frequently appears to react satisfactorily, this is followed in a few hours by a complete slump which cannot be combated by any means whatsoever. It must be understood that I am speaking of extreme cases, not the cases in which the surgeon gets rattled without much cause, as the young doctor does with his numerous cases of post-partum hæmorrhage. The books all say that the benefit in intravenous salt infusion results from filling the depleted arteries and giving the heart something to work upon. The writers are reasoning on the supposition that the condition is a mechanical one, forgetting the phenomena of nervous shock, and the consequent vasomotor paralysis of the abdominal system. It must be remembered, however, that this may occur and death follow from a blow in the epigastrium, and not a drop of blood be lost. One who has removed varicose veins knows the great distensibility of the vessels, and how an undistended vein may contract to a comparatively small calibre, but with intravenous pressure may become enormously dilated. While the vaso-constriction is normally present the equilibrium of the blood-pressure is maintained, but in shock this constricting power is lost; and what is to prevent the saline solution from emptying itself, with the blood, into the abdominal vessels in the secondary shock which may follow a severe operation? This, to my mind, explains why patients die

after an apparently perfect reaction following the intravenous salt infusion.

Now, the question occurs, What shall we do if this supposed prop and safeguard is knocked out from under us? To me the answer seems plain enough. Don't put the saline solution into the vessels which easily lose their tone and dilate, but *outside* of them, and where it will make pressure on them and prevent their extreme dilatation; and the proper place to put it is in the peritoneal sac, and to fill that to the utmost. This tends to prevent visceral congestion. It allows the appropriation of the fluid as the system requires. It is absolutely un-irritating and innocuous. After abdominal operations it dilutes any material which may possibly remain in the abdomen, and it gives the intestines a good opportunity to arrange themselves in their proper position. My belief is that in all cases of severe shock or hæmorrhage occurring from operation, even extra-abdominal in character, it would be far better to make a slight opening into the abdomen and fill the peritoneal sac to its utmost with hot saline solution, and then fasten it up tight. I have left the abdomen filled with hot salt solution many times after prolonged abdominal operations where the patient was suffering from shock, and always with the most satisfactory results. I believe it is much better and quicker in its results than the injection into the tissues, and certainly far less likely to be followed by unpleasant consequences.

In this article it must be understood that I do not condemn intravenous saline infusion as useless, but that I consider that it has much less value than it has been credited with. On the other hand, I believe the filling of the abdomen with hot salt solution, and keeping it there, to be a reasonable procedure, and one which will be found to be followed by better *ultimate* results than the intravenous method.

TREATMENT OF OBSTINATE CYSTITIS.—Dr. G. Hopkins has obtained good results in cases of obstinate cystitis with vesical irrigation of a 20 per cent. solution of glyco-thymolin, and, indeed, where other measures have failed.—*Centralblatt fuer Chirurgie*, No. 20, 1902.

THE TREATMENT OF CANCER BY THE X-RAY, WITH SOME COMPARISONS WITH THE VIOLET RAY.

BY WILLIAM HARVEY KING, M.D., NEW YORK.

(Read at the meeting of the Am. Inst. of Homœopathy, held at Cleveland, June 17, 1902.)

THE ever broadening field of therapeutics has led the medical profession into various paths. Some of the remedial agencies thus acquired have stood the test of a ripe experience, while many more have fallen by the wayside. One of the most recent additions to therapeutic resources is radiant energy.

It has long been known that the sunlight was destructive to germs of various kinds, but to produce this same form of radiancy artificially, and handle it in a way that it might be used in special forms of disease, is comparatively of recent origin; or, at least, the systematic development of it is recent. The sources of this radiant energy are the violet ray of the white light, and the X-ray. There is a third source which bids fair to rival these two, and that is the radiant energy which emanates from radium, a supposably new element which has recently been obtained from uranium by Madam Curie, a Polish chemist; but this radiation has not yet been used sufficiently to give it a definite place in therapeutics.

If we examine more closely into this subject we find that the radiant energy which possesses the power of destroying diseased germs, or, in other words, that has therapeutic properties, has certain peculiarities. For instance, if we take a sunlight ray and divide it into its spectral colors, those rays which, on account of their less refractory power, are found at the red end of the spectrum, and which possess great heating properties, do not have, to a marked degree, at least, any therapeutic properties. As we go along up the spectrum scale, that is toward the end of the greatest refractory rays, we find that as the heat rays disappear, chemical rays appear; and when we come to the extreme, the violet and ultra-violet rays, we get the maximum of chemical action of the sunlight rays. It is these violet and ultra-violet rays that have therapeutic action. If we examine these so-called therapeutic rays a little closer, we find

that they possess other distinctive properties. The red and other rays at the contiguous end of the spectrum are of a form of vibration different from those of the violet and ultra-violet rays, the latter being of a finer vibration, and are very rapid in their rate of vibration.

Following along this same line, we find, as we go up the scale of fineness and rapidity of vibration, the next ray we come to beyond the violent ray is the Becqueral ray, first discovered by Becqueral as emanating from uranium, and known now to come from radium, which, as stated, has been separated from uranium as an independent element. These rays possess a very powerful action on living tissue as well as on germs of various kinds. It may be, when the radium is obtained in a purer state, that the radiations from this element may prove of greater therapeutic value than are those of the violent ray, or perhaps even of the X-ray.

Still farther up the scale is the X-ray. The rays emanating from the excited vacuum-tube, known as the X-rays, are undoubtedly the finest in amplitude, and the most rapid in rate of vibration, of any known to-day. These rays also possess a great effect on living tissue and on bacteria.

Undoubtedly the most interesting point connected with this subject from a purely scientific standpoint is, how do these radiations act? What is it about them that gives them the power to destroy living tissue, and to destroy bacteria? This is a subject that might occupy many pages, and yet no conclusion be reached. It may, however, repay us to glance at a few of the many theories which have been put forward as an explanation of this interesting part of the subject.

First, the chemical theory. It is held by some that it is purely the chemical action of the rays which produces the therapeutic effect, and in proof of this theory it has been cited that, taking the spectrum as an example, the therapeutic properties of the white light develop as the chemical qualities increase.

If, however, we were to follow this same theory to a logical ending, we would be forced to conclude that the violet ray would have much greater action on living tissue and bacteria than the X-ray, as its chemical action, as demonstrated on the photographic plate, at least, is much greater; and yet experi-

ence teaches us that a violet ray does not produce the effect on living tissue or on germs that the X-ray produces.

Just here let us inquire, Does the X-ray and the violet ray act the same? This question cannot be settled with certainty just now, but I believe they do. In treating lupus vulgaris and some other forms of superficial disease with the violet ray and the X-ray, the process of cure is so similar that I am forced to this conclusion. In lupus vulgaris, for instance, both with the violet and X-ray, the tubercles dry, shrink, and loosen at the edges. It would be impossible, by watching the process of cure, to tell which form of ray had been used. The one difference noted is, that if the X-ray be given with sufficient force, the process of cure is more rapid.

A second theory is that ozone is set free along the path of the ray; and, as ozone is known to have great germicidal action, it has been thought that it is from this source that the therapeutic effect is produced.

Ozone is certainly a great germicide. When we come to compare the effects of the two rays as ozone producers, we find that the violet ray is greatest as shown in its power to deodorize, and in the oxidation of various chemicals; yet its action on living tissue is less. With the Becquerel ray the oxidizing effect is even less than with either of the other two; but its action on living tissue, as well as on bacteria, is very strong. While ozone may play an important part in the therapeutic properties of radiant energy, there must be other properties as well.

A third theory is that the great force and fineness of these rays bombard, as it were, the tissues, and thus produce destruction of tissue.

A fourth theory, which has the advantage of being scientific, is that ions are set free along the course of the ray, similar to the ions which are set free by the passage of a continuous current, and that these ions act on living tissue as well as on bacteria. We know, however, that ions are set free in much greater abundance by the passage of a continuous electric current than they are by the passage of an X-ray, and have no such therapeutic effect. Therefore, if ions do play an important part, they must differ in their nature from anions and cations.

Other theories, such as the electric and magnetic, as well as

many more, have been advanced, but in all there seems to be some weak spot, which is pretty evident proof that we have not as yet arrived at an entirely accurate conclusion.

Another important question is, What is the nature of the action of this radiant energy on diseased and healthy tissue? The violet ray possesses less destructive action on healthy tissue than does the X-ray. Further experiments must decide whether the X-ray's greater power over disease germs and its greater therapeutic value are in proportion to its destructive action as marked on healthy tissue; but certain it is that the X-ray leads the violet ray in both respects.

The Becquerel ray also possesses marked action on living tissue as well as on germs. I have seen a case where a dermatitis was produced over the left breast from carrying a small vial of radium, hermetically sealed, in the vest pocket. This dermatitis resembled, so far as inspection could determine, the dermatitis produced by the X-ray.

The most interesting point in this connection is, Why is diseased tissue destroyed and yet healthy tissue remains unaffected? Why do we not necessarily destroy one when we destroy the other? As a fact, we do not, for it is possible to destroy diseased tissue and at the same time healthy tissue may be stimulated, healthy granulations formed, and the wound heal rapidly.

Of course, these good results are obtained only when the treatment is given with judgment, for if the power of the ray be concentrated too long upon the part, healthy tissue is destroyed as well as diseased tissue. Here comes in the great judgment and skill of the operator in carrying the treatment far enough to destroy the diseased cells, and short of enough to affect healthy tissue. More than ten years ago Dr. J. Ingals Parsons, of London, discovered that when certain heavy shocks of electricity were passed through cancerous tumors, they would destroy the cells of the involved tissue, and not the cells of the healthy tissue. He at that time put forth the theory that, as diseased cells did not have the nerve-supply that healthy ones had, and were not so well supplied with nutrition, they had less power of resistance, and, consequently, were the first to be destroyed. This undoubtedly explains the action of the X-ray.

Gröen, * at a recent meeting of naturalists and physicians held at Hamburg, reported having made microscopic examinations of sections of tissue treated by the X-ray, with the following results: Healthy tissue was less affected and showed fewer changes than the pathological tissue. In the latter the main degenerative process consisted of hyperæmia, with marked emigration of leucocytes, formation of vacuoles, and breaking down of the epithelial cells.

When we come to the practical application of the X-ray to cancers, there are several points which should be considered, as it is only by following a prescribed technic that success is the reward. The different points which may be considered with regard to the technic are: (a) the tube; (b) the exposure; (c) the results of the exposure and the process of repair; and (d) the selection of cases and the prognosis.

(a) The tube. A general division of tubes has been made into hard and soft. By the hard tube is meant one in which the vacuum is high, and requires a greater voltage of current to excite it. This kind of a tube gives off a powerful X-ray, one that is capable of great penetration.

By a soft tube is meant one in which the vacuum is low. These tubes may be excited with a less intensity of current, and give off a correspondingly feeble X-ray, which is not capable of great penetration. There is no question which of these tubes to choose when the cancer is deep seated, as the ray emanating from the soft tube does not penetrate sufficiently to produce the required results on deep-seated tissues.

A case which has recently been treated by me illustrates how much more effective a hard tube is in treating deep-seated cancers. It was an osteo-sarcoma of the pelvic bone, which was treated for ten days with only a slight relief of the pain, with a soft tube, one which gave a good fluoroscopic view of the bones of the hand, but not of the chest. A hard tube was then substituted for the soft one, and the relief was marked from the first treatment. With superficial cancers the soft tube may be used, but I believe it is always inferior to the hard tube.

(b) The exposure is the most important part in treating can-

* *Centralblatt für die gesammte Therapie, Vienna, Austria.*

cers with the X-ray. The distance the tube is from the patient should never be less than six inches, and never more than twelve inches. If it is nearer than six inches, I believe the tendency to burning is increased without corresponding benefit; and if more than twelve inches, the efficiency of the treatment is lessened.

The time and frequency of the exposure is also most important. I originally treated cases three times a week, and continued the radiation from twenty to thirty minutes. I have, however, come to the conclusion that more frequent treatments, even daily, with a shorter exposure, say 10 or 12 minutes, is more effective, and that the danger to burns is not so great. The number of treatments which each shall receive must depend on the individual case. No two cases will respond precisely the same, no matter if the disease happens to be of the same nature.

(c) The results of the exposure and the process of repair. It may be stated, as a fundamental principle, that there should be no undue burning of the tissues. A little redness of the skin need not contraindicate a continuance of the treatment; in fact, I always carry the treatment to the point that a little redness is apparent, as this slight action on healthy tissue is a sure indication that diseased tissue is being affected. This redness, however, should be carefully watched, and it will be found, after a few days, that the redness is apt to give place to a dark discoloration of the affected parts; the degree of this darkening of the skin depending on the complexion of the patient, being greater in brunettes than in blondes. If at any time this redness should increase and become angry looking, and there should be a tendency to desquamation of the epidermis, the treatment should be discontinued until all signs of the desquamation disappear.

In open sores that are discharging, the discharge should begin to decrease from the first; and if, after a number of treatments have been given, with a decrease of the discharge, it suddenly increases, the treatment should be lessened, or even discontinued for a short time. The rule is to give all the radiation that can be borne without producing destruction of the healthy tissue. After the operator has become experienced, he will not have much difficulty in so gauging his treatments as to obviate

all tendency to burns, and yet produce the desired effect on the diseased tissue.

When the cancer is internal, or even external, and the skin is not broken, the first effect should be relief of pain. There may develop occasional slight stinging pains, which are probably due to the radiations. I have noticed this in a few cases, but they did not seriously inconvenience the patient and soon disappeared. The deeper-seated pains should decrease from the first. Next, the tumor should shrink in size.

When the case is one of open sore the pains should also decrease from the first, the discharge should lessen, and healthy granulation begin to appear and increase until the surface is healed over. Infected glands are more or less affected by treatment directed to the original sore; but I have found it necessary to treat the separate nodules of infection when they are located in places where the rays do not come in contact with them.

One case I treated illustrates this point. It was a sarcoma of the cheek, with a large secondary nodule on the neck just below the original sore, and another enlarged gland on the opposite side of the neck. The rays given to the original sore also came in contact with the nodule underneath it, and this decreased in size; but the one on the opposite side showed no sign of decreasing until treatment was given to it direct.

(d) The selection of cases and the prognosis is, as may be supposed, owing to the short length of time the treatment has been given, not as yet thoroughly worked out. Rodent ulcer and epithelioma are the most easily and surely cured. Next to this, sarcoma; while carcinoma is also curable in many cases.

In those cases, however, in which there is the least involvement of the glandular tissue, and where the patient presents a good general appearance, the prognosis is the best. The prognosis of internal cancers, by which I mean those deeply seated, is not so favorable as those on the surface. An open wound, of course, always makes the liability of absorption greater, and consequently makes the prognosis more hazardous; but it should by no means cause one to hesitate in using the X-ray, as some of the finest cures I have seen have been in open cancers.

In closing, I wish to state that I thoroughly believe we have in the X-ray, and in other forms of radiant energy, a valuable addition to our methods of treating cancers, tuberculosis, and

perhaps many other forms of disease. I recognize at the same time that there is great danger, in our enthusiasm, in holding out too alluring hopes, and thus leading the profession to expect more than can be accomplished. If such should become true, the pendulum is sure to swing too far the other way, and for a time a really valuable therapeutic agent will be neglected. It will, however, sooner or later right itself. I trust, by conservatism and close observation, that the X-ray and other forms of radiation may be spared that period of reaction.

TINCTURES VERSUS FLUIDS—A LAST WORD.

BY EDWIN A. BENDER, PH.G., PHILADELPHIA, PA.

MY suggestion that the preparations known as “fluids”—not fluid extracts, as one of my critics seems to infer—represent an advance over the tinctures prepared for the use of homœopathic practitioners according to the traditional method seems to have aroused a storm of protest from those interested in the latter. Nevertheless, their very protests, read critically, vindicate my assertions. Let me review certain of their contentions:

1. That the fresh-plant tincture should be used, because it is the preparation with which the provings were made. This is manifestly untrue, if we are to accept the statements of Allen’s “Encyclopedia.” Reference to this work, with which I would have expected every orthodox homœopathist to be familiar, reveals the fact that the provings are based upon experiences with all sorts of drug preparations, varying from poisoning cases, with the crudest substances, to instances in which a single dose of a 1000th attenuation was given and every subsequently-occurring symptom noted. In addition, there is a great collection of “clinical” symptoms, *i.e.*, symptoms not caused by the drug, but which were already present and disappeared after its administration—“indications” which constitute pure empiricism. In these facts I fail to recognize any reason for believing the green-drug tincture to be in any sense more representative of original provings than its confessedly more active and definite rival, the fluid.

2. That, as one writer naively contends, the green-plant tincture is more nearly representative of the living plant. This ingenuous plea would deserve more consideration if it could be demonstrated that life, either animal or vegetable, were conserved by immersion in dilute alcohol. As a matter of fact, neither this nor 95 per cent. alcohol does anything of the kind; but, fortunately, the medicinal virtues of plants are definite chemical substances, and, as shown by the table which Dr. Carmichael wishes to disregard, are in general far better extracted by alcohol than by water.

3. That the globules or pellets are not designed for the administration of "active preparations of definite strength." Conversely we must, I presume, consider them as useful only for dispensing drugs which are either inactive or of indefinite strength. Possibly it would be fairer to assume that the writer meant to imply that they are intended only for the use of those who prefer attenuations of the drug above the second decimal. For the benefit of Dr. Carmichael, let me say that I am acquainted with a large number of homœopathic physicians, men whose professional standing and success would suggest that they possessed at least a fair allowance of my critic's much-prized "pharmaceutical sense," who do not acknowledge for an instant that a belief in the law of similars binds them to a belief in extremely small or infinitesimal doses. These men prescribe homœopathically, not for the so-called physiological action of a drug; and they know that they can do it, without fear of inducing medicinal aggravation, by medicating the convenient globule. It must be remembered that it is a long call from the hundredth or thousandth of a drop to the drachms or ounces necessary to induce the physiological action of most drug-preparations, and that the middle-ground between these extremes of dosage is that occupied by a large proportion of homœopathic practitioners to-day.

A contention everywhere manifest, though not expressed in so many words, is that the old preparations are those with which results were achieved in the past; so why not "leave well enough alone"? This position would be much more tenable if there were more physicians who could honestly state that they have never been disappointed in a properly-selected drug. So long as such disappointments do occur—and how

frequent they are, every reader of this must know to his sorrow—so long will practical physicians seek to secure better drug-preparations, hoping thus to prove that the medicine, rather than the principle of drug-selection, has been at fault. The alarm of my critics is, therefore, ill-advised. If the fluids are valueless, and do not, in professional hands, prove to be an improvement upon the old preparations, they will fail to retain the confidence of their users, and will disappear spontaneously. If, however, these preparations do achieve results for the physicians who use them, no amount of *a priori* argument will prevent their general adoption. In this, as in other cases, the bedside-test will prove more than will pages of discussion.

WHICH SHOULDER SHALL BE DELIVERED FIRST?

BY C. E. FISHER, M.D., CHICAGO.

DISCUSSION of how best to save the perinæum in labor being always timely and in order, special value attaches to the excellent article by G. Maxwell Christine, M.D., Philadelphia, in the *HAHNEMANNIAN MONTHLY* for June of the current year, upon the relation of the delivery of the shoulders to this important subject. Previous contributions to this phase of delivery are to be found in the *Medical Century*, of which I was at that time editor, in the issue of June 1, 1895, volume iii., page 248, by T. G. Comstock, M.D., of St. Louis, and W. C. Richardson, M.D., of the same city—perhaps the articles to which Dr. Christine refers, but which he has been unable to locate; especial value attaching to Dr. Comstock's treatment of the subject because of its elaboration and fullness.

Long before reading the contributions referred to, it had been my rule to deliver the anterior shoulder first, chiefly because I had found it easy of practice and as facilitating the completion of labor. I have not found it necessary, nor especially desirable, however, to hurry the delivery of this part, because of danger to the child from asphyxiation, as suggested by Dr. Christine, since I have never found post-head-delivery contraction of the perineal tissues sufficiently firm to endanger the baby. No matter how blue the face of the child may become

prior to the delivery of the body, I feel no concern on this score. Several minutes nearly always elapse, in even the most normal of labors, between the birth of the head and the birth of the body. Nature demands these moments of rest; nor have I ever found them of danger to the child. Of course, this does not apply to unusually long detention of the trunk in the parturient canal, nor to retarded body delivery from foetal abnormalities. But the degree of asphyxiation depending upon thorax compression or neck-constriction subsequent to the expulsion of the capital pole has never been sufficient, in my experience, to occasion the slightest concern. A few moments of cord pulsation before the cord is tied has always cleared up this venous stasis. In fact, I depend almost wholly upon the continuance of the maternal circulation for resuscitation purposes, never tying the cord until the pulsations are good and strong, unless they go in the opposite direction, indicating separation of the placenta and foetal siphonage.

I have not found it necessary to place the patient in the position described by Dr. Christine, namely, across the bed, with the hips well toward the edge, in order to get the benefit of gravity of the foetal head and trunk, as the child is born, upon the perineal tissues. The English position, the woman on her side, with her back toward the accoucheur, accomplishes the same result, and requires no assistants to hold the limbs in the flexed position. Ordinarily, the head may be sufficiently depressed against the perinæum to accomplish all that is necessary, with the woman in the dorsal decubitus. It is plain, however, that in extreme cases the practice outlined by the author whose contribution is under discussion may be of very great value.

Not alone because of the greater safety to the perinæum is it desirable that the anterior shoulder shall be delivered first, but because the safety of the anterior tissues, including the urethra, is conserved by the procedure. In order to deliver the posterior shoulder before its fellow is brought down there must be a good deal of forward pressure of the head, and also of the acromion process of the unborn shoulder. This pressure is directed upon the urethra and against the meatus urinarius. These tissues and the anterior fourchette suffer, and their suffering is of a nature to cause a great deal of discomfort. It

was protection of the urethra, rather than protection of the perinæum, which caused me to first practice delivery of the anterior shoulder.

Nor have I found it necessary to rotate the body of the child, after anterior shoulder birth, prior to the delivery of the posterior member. This occasionally occurs through nature's efforts. But my practice has been to deliver the anterior shoulder between pains, when possible, and then to allow the child to lie with the pressure of its weight against the perinæum until a normal pain occurred. The transverse diameter of the fœtal trunk will have been lessened by the diameter of the delivered shoulder and arm, and thus more room will have been gained for the trunk as it glides out over the perinæum. It is now the shoulder, and next frequently the posterior elbow, doubled, that tears perinæums in my practice. If I can get the anterior shoulder away between pains I can almost certainly guarantee against perineal injury as the posterior shoulder and arm are being delivered. But if the anterior member be held back, the danger to the perineal tissues is greatly increased.

EXOPHTHALMIC GOITRE.

BY WILLIS B. GIFFORD, ATTICA, N. Y.

(Read at Annual Meeting of Western New York Hom. Med. Society, Buffalo, April 11, 1902.)

IN this brief paper I shall not go into the pathology or etiology of exophthalmic goitre, as I merely wish to show the effect of homœopathic remedies in a very aggravated case. In October, 1900, I was called to Buffalo to see Mrs. E., a resident of Cattaraugus county. She had come to Buffalo to consult one of the leading allopathic physicians, and had been here some six weeks. Growing rapidly worse, upon the advice of three different allopaths she was removed to a hospital and a surgeon called, who gave an unfavorable prognosis and advised an operation as the only thing which offered the slightest hope. This being declined, the husband concluded to try homœopathy as a last resort. I found her in a very unpromising condition; pulse 160 and irregular, large arteries at the root of the

neck throbbing forcibly, visible pulsation of peripheral arteries, sounds of the heart very intense, eyeballs protruding, enlargement of thyroid, the neck measuring 20 inches, and the whole gland pulsating (anasarca), the œdema extending from toes to knees; urine scanty and slightly albuminous. She complained of forcible throbbing of the arteries, accompanied by unpleasant flashes of heat and perspiration, and a severe pruritus involving the whole body. She was much emaciated, very nervous and restless, and greatly prostrated. She suffered from extreme thirst, calling for water frequently, but drinking little at a time.

Realizing that immediate relief was demanded, I prescribed arsenicum, 6th decimal, this prescription being based upon the general irritability, extreme weakness, emaciation, tremblings, restlessness, frequent jerking during sleep, and the character of thirst and cold sweat on face. The following day I found her less restless, and, upon the whole, in a slightly better condition. I continued the arsenicum for several days, and her general condition seemed much improved. Upon closer inquiry I found she had been heroically dosed with every and all remedies ever prescribed by the old or "scientific" school; digitalis to control the heart's action, strophanthus for the same purpose, strychnia to arouse and sustain the vital powers, morphine and bromide of potash to depress them, compound cathartic pills to move the bowels, bismuth, chalk and paregoric to restrain them, iodide of potash and ergot to squeeze the blood out of the thyroid and absorb it, and pepsin, bismuth and salol to control vomiting caused by this heroic dosing. I think that there were several other remedies given, but the list is too long for my memory—yes, I omitted to mention sulfonal and hyoseyamus to produce sleep. All of these remedies were given at one time by these "scientific" physicians.

I made a very close study of all the symptoms in this case, and determined to forget the name of the disease, its etiology and pathology—in other words, to find the similar remedy, if possible, and to prescribe for the patient. Here are the symptoms upon which I based my prescription: Emaciation; weakness after the slightest effort; worse at 4 P.M.; anxiety with depressed mood; easily startled; more or less loss of comprehension and memory; difficulty in lying down on account of

throbbing in brain; roaring in the ears; over-sensitiveness to noise; no appetite; distention of the stomach after eating even a small quantity; heartburn; frequent desire to urinate, with burning; red, sandy sediment in urine; menses too frequent and long-lasting; cough, with gray, salty expectoration; more or less dyspnœa; nights restless, with anxious dreams; fever and sweat every afternoon, with thirst. Yes, you will say "lycopodium," and lycopodium she received, with the result that she was removed to her home in two weeks, very much improved. This remedy was continued for a period of six weeks. I received daily reports by telephone. At this time the husband thought I had better make her a visit, which I did, and was astonished to be met at the door by her. The enlargement of the thyroid had nearly disappeared; her pulse is 78, the eyes are very much improved, the bulging being scarcely noticeable; in fact there has been a gradual disappearance of all the symptoms above enumerated. Last summer she visited the Pan-American frequently, and her husband said she could tire him out. Up to the present time her general health remains good.

THE DIAGNOSIS OF INSANITY BY THE GENERAL PRACTITIONER, WITH ESPECIAL REFERENCE TO COMMITMENT TO ASYLUMS.

BY WESTON D. BAYLEY, M.D.

(Read at the Homœopathic Medical Society of the County of Philadelphia, May 8, 1902.)

THE practice of medicine, full at all times of serious responsibilities, has none greater than are involved in its relationships with the insane. Not only is the doctor a judge whose edict can deprive a person (of supposedly unsound mind) of his personal liberty, but an arbiter upon whose professional word such a person may lose his civil rights, and have his domestic and financial affairs pass under the supervision of others. These powers, vested primarily, at least, with the physician, while necessary and proper, incur the possibility of two sources of injustice to the person under consideration—first, by a criminal conspiracy against one who is not insane; and, second, through the perhaps unwarrantable commitment of some one not really

of unsound mind, through the ignorance or inexperience of the medical attestors.

Fully cognizant of these two sources of evil, legislation has, in various ways, tried to at least minimize them. The laws of Pennsylvania, for instance, require a certificate, signed by two physicians, and sworn to before a judge or magistrate, certifying that the examination has been made within one week prior to the date of signing; that the examinations were separately made; that the signers believe the person to be insane; that such disease is of a character requiring (in their opinion) institutional care; that they have been in practice for at least five years; that they are not related by blood or marriage to the person to be committed, nor in any way connected, as medical attendants or otherwise, with the establishment in which it is proposed to place him. And any person falsely certifying as aforesaid shall be guilty of a misdemeanor, and also be liable, civilly, to the party aggrieved.

Thus does the certification of insanity become a serious and responsible duty for the medical practitioner—a duty made difficult not only by the foregoing considerations, but by others, in the circumstances and environments of individual cases, which will be referred to later; and it may be not unprofitable for us to devote the time allotted to me by your Board of Officers to a discussion, from the standpoint of the general practitioner rather than the specialist, of the principles of examination and diagnosis in affections of the mind.

In such a study we are confronted with difficulties at the very outset; for we find that our very definitions of insanity are entirely empirical, and of little or no scientific value. The differential between sanity and insanity is not like the sharp line of demarcation between rocky cliff and restless ocean, but rather resembles those lowlands which gradually merge into the sea, with intervening, unmeasurable strips of half-submerged coast, which is neither navigable nor fit for habitation. This analogy may be crude, but it serves to illustrate that well-recognized but perplexing borderland where so many are ankle-deep in the bogs of eccentricities of conduct, querulous or weak-minded degeneracy, without being fully submerged in the deeper waters of actual lunacy. Nay, our analogy may be extended even farther than this; for out in that blue water we can,

by "heaving the lead," measure the varying depths (corresponding to the classified forms of mental disease), and ascertain that one depth gradually merges into another; that is, that our text-book classifications only define types, between which, in actual experience, are found intermediate varieties—again borderland cases—which conform with no one recognized kind, but present the mingled characteristics of several. The fact is, our science of mind, both mental and morbid, is at present but crude and fragmentary. A careful study of new lights, which are beginning to glimmer in some of the dark places of our subject, has led me, after much deliberation, to believe that we are on the verge of a complete reconstruction, on entirely new lines, of our views of mind, and its relationship with the brain and body. The ultimate of this is now only dimly foreshadowed; but it is known that our ordinary consciousness, that which we call "ourself," is only a segment of the sphere of actual individual being; and it is more than probable that insanity and allied affections are due to the irregular projection into our ordinary consciousness of fragments of the larger self, or, conversely, a sinking of some of our "work-day" faculties into the perplexing realms of sub-conscious being.

This view, to which we may recur, not only accounts for the origin of the established types of insanity, but also renders intelligible those partial and fragmentary forms which fill-in the hiatus between mere eccentricity of conduct and unmistakable aberration of mind.

Attempts to classify insanity, like the efforts to define it, have not been altogether satisfying. No better proof of this is needed than a statement of the fact that there are as many different classifications as there have been authors to create them. And must we learn all of these? "Madame," said Heine, speaking of his boyhood days, which were in the time of the great Napoleon, "it is not my fault that I learned so little of geography, for in those days the French made an intricate mixture of all limits and boundaries; every day, lands were recolored on the world's map; those which were once blue suddenly became green; many, indeed, were even dyed blood-red; the old-established rules were so confused and confounded that the Devil himself would never have remembered them!" In

a cloister near his school-room there hung a dismal, gray wood image of Christ crucified, which gazed sorrowfully at him with fixed, bleeding eyes. "On my way to Latin lesson I often stood and prayed: 'Oh, thou poor and also tormented God; I pray Thee, if it be possible, that I may get by heart the irregular verbs!'" I am not about to inflict upon you a new classification!

The oldest method of classifying insanity was the symptomatic. Thus originated the classes in Mania, Melancholia, Dementia, and the like. Next came the etiological method, that of separating cases according to their supposed causes. Of such are Puerperal, Climacteric, Senile, Alcoholic Insanities. Later came the pathological method, as is instanced in meningo-encephalitis. This pathologic method would be the most desirable could it be generally applied; but unfortunately, in the present day, mental pathology is such a mere glimmer that we cannot grope very far in its uncertain light. The classifications of to-day are mostly a combination of all three methods.

It is with no disrespect for these careful and often ingenious attempts that I am going to ask you to depart, for our present purpose, from the established classifications of mental disease, for one of no scientific pretensions whatever—a mere grouping, but one which seems to have been tacitly adopted by the average doctor almost universally.

(1.) Cases so typical or advanced that the lay friends of the patient have already made a diagnosis, which you simply confirm.

(2.) Cases in which the general practitioner, with average experience, will determine the existence of insanity, even though he be undecided as to its variety.

(3.) Cases involving difficulties which even the specialist, with all of the resources of his study and experience, will be unable to fully interpret.

In determining either the existence or the character of insanity in a given case, not only are you confronted with the ordinary diagnostic difficulties, but you also assume moral and legal responsibilities of considerable gravity. After making a diagnosis you may have to defend or explain it in a court of law; and, since neither law nor psychiatry are exact sciences,

there is no predicting what might happen in exceptional cases. Remember that sinister motives on the part of relatives of a patient may mislead you into interpreting as insanity some more or less reasonable eccentricities manifested by their patient, who is, perhaps, unduly influenced and under their domination. This may be done deliberately, in order to secure control of property which their victim may possess. Therefore, as a matter of justice to your patients and protection to yourself, always take glowing descriptions of the aberrations of a prospective patient with grains—yes, even bags—of salt. Frequently enough have sane people been deprived of their liberty and the control of their belongings through the gullibility of the medical attendant.

On the other hand, some of the most hopeless and dangerous of lunatics are so plausible, so logical, as to be almost able to convince judge, jury and audience of their seemingly unwarranted detention in an asylum. And for the same reason it may prove difficult to secure legal recognition of mental incompetency in these very cases in the event of their having committed a crime.

When called upon to examine a patient with the view of commitment, secure, if possible, in advance, an account of his or her antecedent history, the age, occupation, environment and family history. This data is usually obtainable from the family before you interview the patient. In making this record it is well to consult several of the immediate friends, for in this way we may secure supplementary testimony, perhaps of importance. Such a history should be obtained and recorded methodically—commencing at the beginning (and making sure, too, that it is the beginning), and progressing systematically down to the present time.

Too many of our records are mere rambling haphazard notes of the unguided narrative of a patient or his friends. It is desirable, of course, to avoid influencing descriptions of illness by any sort of suggestion on the part of the recorder; yet at the same time it is not difficult, by judicious handling, to secure such information in consecutive order. If there be traumatic history, inquire into the details of it. Note whether there was anything unusual in the patient's physical condition, or in his environment at the time of, or just before, the appearance of his aberration of mind.

With this information in our possession, we are now prepared for our examination of the patient. What has been thus ascertained in advance usually furnishes the cue for the best method of interrogating the particular case in hand. It is desirable to verify, from the patient's own statement or action, the accounts of the symptoms as previously given by the friends; and we must bear in mind the necessity, too, of analyzing a patient's delusions; for, after all, there may be a substantial basis for some apparently morbid ideas. Not even general directions can be given for the conduct of this examination; since, on the one hand, the patient may be too inattentive or morbidly pre-occupied to reply to any questions, while, on the other, he may be fully able to evenly match your professional skill with a morbidly acute cunning. Much tactfulness is at times requisite in getting the patient to talk of his particular delusion. He may appear quite rational, or else silent and taciturn, until some suitable remark of yours uncovers his weakness and gets him started. In conversation with some of these cases I have thus fished about for a good while before casting the line into their morbid spot! Indeed, to secure even an approach to a satisfactory interview with some patients, it may be necessary for you to approach them in some assumed capacity, entirely concealing your identity as a physician. In examining violent or homicidal cases, a self-possessed, tactful attitude—even though your heart is actually impinging, like the globus hystericus, against your larynx—may be sufficient for you to successfully conduct an examination; but it is best to secure the presence or accessibility of enough assistance to promptly control the patient in case of need. Some years ago I saw, at the instance of the late Dr. Buchman, a woman whose latest obliquity was to serve her husband an old shoe, appropriately boiled, in a covered tureen for dinner. She was alone in the house when I called, and, perhaps divining the object of my visit, she would have refused me an entrance had I not held the door open with my foot. I was received in the dining-room with all kinds of angry threats, an emotional state which increased to a perfect rage, and then as suddenly became a dominant fear, in which she rushed out through the kitchen into the yard, where she fastened herself in the water-closet. All persuasion for her to come out proving of no avail, I pulled

up a chair that was in the yard, and, standing on it, finished my necessary conversation with her through the semicircular hole cut in the top of the door for ventilating purposes. It did not occur to me until later what a real sacrifice of dignity I was making, and how totally incomprehensible such a dramatic procedure must have appeared to the neighbors, if any happened to be spectators.

Conversation with the patient will disclose the prevailing emotional tone; the degree of impairment (if any) of attention, memory and judgment; the character and coherency of the delusions; and the degree of self-consciousness which the patient may have of his abnormal mental condition. We must examine for relational and coincidental disease of the general nervous system; for instance, the remnants of an old hemiplegia may be found, or, in paresis, you may demonstrate a co-existing or preceding locomotor ataxia. In cases particularly where you are to prognosticate or conduct the treatment, every organ in the body must be examined and its function interrogated. The idea is too prevalent that this, that or the other form of insanity is a distinct entity-like pneumonia, and that diseases or morbid conditions of remote organs are of but casual association. I have known this erroneous notion to prevail even in one of our large asylums (if we can judge by their failure to look for and rationally treat conditions other than the strictly mental ones). Such distant lesions have so frequently been demonstrated as direct, or at least contributing, causes of insanity, that every source of reflex irritation should receive early attention, and any existing general disease its appropriate treatment.

The commoner forms of insanity are so well understood by the intelligent laity that the physician is usually given a correct diagnosis at the time of being consulted in reference to a case. In acute mania have they not, indeed, read and re-read the pitiful story of Ophelia, who, stunned by her lover's sudden change of heart and crushed by the murder of her father, becomes acutely insane, her mental excitation being shown by her rapid, disconnected sentences, intermingled with snatches of disjointed verse; her ceaseless, restless activity; and, finally, her death—not suicidal, but accidental—in her unhesitating rush for flowers growing out of the water? Melancholia. Are

they not familiar with the depression and terrific lamentations of Mrs. Gummidge, as she sits by the fireplace in Mr. Peggotty's old house-boat "a mournin' for the old 'un?" And is it not easy to reckon from this simple mental depression on downward to that variety so profound that it plunges its victim into actual stupor?

Circular Insanity would be as well understood if the laity but knew it is an alternation of these two forms—sometimes with a regularly appearing lucid interval—but which incurably continue the clock-like changes for the balance of a life.

Dementia they know of, in its mild senile form, in the character in "David Copperfield" of Mr. Dick, who could not keep Charles I. out of his "Memorial," the pages of which he forthwith strung into kites. Terminal Dementia is, of course, less known; but the physician well understands it as the grand finale of many chronic and incurable types—a sort of Sargasso Sea for mental wrecks.

The layman has some knowledge, too, of our Primary Delusional Insanity, or Paranoia, in his experience and observation concerning the hopeless cranks, monomaniacs, and "people obviously with a screw loose somewhere," of his acquaintance.

Excepting in the typical cases, however, paranoia is a mental condition which has given rise to much confusion not only to the general mind, but in our courts of law and among practitioners of medicine as well. This is for two reasons. First, that this is a condition which grows out of (often gradually) the apparent eccentricities of childhood; that is, the adult paranoiac has usually been a willful youngster with a "cussed" disposition; and these are the early but usually recognized expressions of the disease. Second, there being, in this disease, no disturbance or impairment of either memory, judgment or emotion, but simply delusions, often appearing so logical as to seem possible realities to one not well acquainted with the patient or the innate peculiarities of this form of lunacy. The delusions of paranoia, then, are systematized; they usually partake of the character of some persecution, and there are hallucinations particularly of hearing and general sensation, so that voices command them; and various appliances, often electrical, are operated in some incomprehensible way by their enemies,

so as to give them direct annoyance. These cases appeal to the police for protection, institute erratic lawsuits, falsely accuse others of serious crimes, and may finally be destructive or murderous.

To make even passing mention of the various other types of lunacy would far exceed the limits of my time and your patience. These make up a large class, which often includes some definite etiological factor, *e.g.*, puerperal, alcoholic or climacteric insanities.

Causes assigned for given instances of insanity are often proximate and hypothetical. Mental failure is not usually an affair of a moment, precipitated by a sudden unusual stress in the patient's environment; but before the mind breaks down there are likely to be some signs of alienation which would be determinable by the physician, and, indeed, which are often painfully apparent to the patient himself.

Insanity has been defined as a "departure from the normal mental status of the individual," and this departure may be recognized, and by painful effort concealed, by the patient himself long before the final outburst. If, at this point, the patient would only confide and the physician discern, how many cases would be nipped in the bud and saved from the asylum! After a case is unmistakable, how often do the friends recall the warnings which should not have been overlooked! Defects in attention, failure of memory, abnormal mental fatigue, hyperæsthesia of the special senses and unaccountable alterations in the disposition, coupled, perhaps, with a neuropathic heredity, are all danger-signals of great moment. At this time we could do most for them, but, unfortunately, they are not yet "technically" insane! The so-called "sub-acute" mania is an instance of this. Here there are no delusions or hallucinations—simply an untoward brilliancy, an undue extravagancy of thought and action, soon terminating in an acute maniacal outbreak which might have been prevented had the appropriate treatment been promptly instituted.

I am not in sympathy with the present ethics of insanity which make its victim an object of chronic suspicion and the commitment to an asylum a term of lasting reproach. If there are charitably disposed organizations whose object it is to look after and help uplift the criminals as they are discharged from

prisons, there is an almost equal need of similar aid for the convalescent or recovered insane. If it is known that these have been inmates of an asylum, they are regarded with suspicion, and perhaps fail to secure employment; and with this stigma upon them, they too soon fall back in their old environment, to which is now added greater impoverishment, and then—well, what but a relapse and readmission?

I want to go on record, in the most unmistakable way, as being opposed to the present system of herding the curable insane in asylums, as being prejudicial to the attainment of the best results; and I want to express my total disapproval of the custom now prevailing of placing these asylum patients under the absolute care of a medical superintendent and staff who are more or less permanent residents in the asylum. The plea that the skill and usefulness of the medical superintendent is enhanced by the highly specialized experience which he thus obtains is not well founded, for the reason that these very limitations, and the constant association with the insane, lead directly and irresistibly to a sort of complacent routinism which even the strongest could not fail to fall into. There is, of course, every need of a resident staff; but let the real directing hands and heads be non-resident, and go in fresh from their broader experience with the more sane on the outside, and give the benefit of this to the less sane within the asylum.

I have already said that the general medical status of the mentally unsound should receive full attention; outside of this the special management of the insane is more or less commonplace, and a matter of tact and good judgment. It is my opinion that our general average of results would be much improved by using the present asylum system, perhaps in some modified form, for the care and detention of the incurable insane, and establish a scattered cottage system, with not more than twenty cases in each small hospital, these to be under the care of general practitioners of known excellence, with a staff of specialists in every branch of medicine at their command for counsel. This system (here only mentioned in the barest outline) would do away with herding and institutionalism; it would secure more individualization in the treatment of the cases, and broaden the lines of that treatment by introducing a freshness of method from without to supplant the psychologi-

cally tired and perhaps moss-grown methods now in vogue within. Because our medical customs and institutions seem fixed and established to our brief human span of observation, we must not let an over-satisfaction with that which we now have make us less conscious of those betterments of method which, in the inevitable progression of things, are yet to come. Rather, like the toilers up a mountain, must we, from one point of vantage, scan the possibilities of the next; and who shall have the temerity to say, in this age of progress and enlightenment, "Behold the very summit of our endeavor! There is now nothing left for us but to rest contented and complacently review the toilsome up-journey from the past"? Asylum methods have not, of late, kept pace with the general advancement of medical technique. Can it be that Mr. Rip Van Superintendent has dozed too long in his easy-chair?

CORRESPONDENCE.

To the Editor of the Hahnemannian Monthly:

Sir: In last month's issue, Arthur W. Yale, M.D., of your city, in his article entitled "The Use of Picric Acid in the Treatment of Pelvic Inflammations," makes the following statement: "Here, again, the suppositories have the advantage over the douche in keeping this strong germicide in contact with the affected parts during the night; also in keeping the vagina acid, thus inducing the gonococci to come to the surface, instead of burrowing in the glands and membrane to escape the alkaline medium in which they do not develop." Is such a fact? "Reference Handbook of the Medical Sciences," vol. i., page 682, says: "All the pathogenic species thrive best in media containing albumin and of a neutral or slightly alkaline reaction." Also, "The reaction of the culture media is of great importance. Most bacteria grow best in a neutral or slightly alkaline media, very few requiring an acid medium, and none of the parasitic species. An amount of acid or alkali insufficient to prevent the development of bacteria may yet suffice to rob them of some of their most important functions,

as the production of toxins." Page 709 of the same volume, under the head of *Gonococcus*, says: "Growth on ordinary culture media is so scanty that special media have been devised for its cultivation, *e.g.*, Human Placenta Serum Agar, Human Chest Serum Agar, which should have a neutral reaction."

Yours fraternally,

J. W. CRAWFORD, M.D.

NORTH ADAMS, MASS.

THE ETIOLOGY AND PROPHYLAXIS OF SUMMER DIARRHŒAS IN CHILDREN. —Heiman defines "summer diarrhœa" as an intestinal disorder of infants depending upon the influence of the heat of the summer and upon micro-organisms as exciting causes. The term is plainly a misnomer, and he suggests that a word be coined in its place embracing those gastric and enteric diseases of child life which reign during the heat of the summer and are accompanied by diarrhœa.

It is now positively known that several intestinal micro-organisms may, under certain abnormal conditions, become specifically pathogenic. The most important ones are: 1. *Bacillus coli communis* (Escherich). 2. *Bacterium lactis aërogenes* (Escherich). 3. Certain staphylococci and virulent forms of streptococci (Escherich, Hirsch and Libman). 4. A micro-organism which infests the intestinal canal, causing green stools, has been described by Lesage and Hayam. 5. Flügge claims that certain saprophytic bacteria have distinct pathogenic properties, acting upon the proteids to cause toxic substances which set up diarrhœa. 6. Baginsky describes a chromogenic and a non-chromogenic variety, both pathogenic, and causing acid stools. 7. Booker and Tissier have both isolated many varieties of bacteria from the stools of infants suffering with summer diarrhœa. 8. Hauser claims that the *proteus vulgaris* is at times virulent.

The predisposing causes are low vitality or an altered state and relaxation of the mucous membrane, due to hot weather, or a pre-existing gastro-intestinal catarrh. Dr. Heiman has noticed that there seems to be a decrease in the number of cases of summer diarrhœa from year to year. This he attributes to the better carrying out of prophylactic measures.

Prophylaxis.—Knowing that micro-organisms play the most important rôle in the etiology of summer diarrhœa, our aim should be to procure for the infant an absolutely pure milk. That obtained in the milk laboratories ("certified milk") is usually a safe food. Overfeeding must also be avoided. The early attention to slight gastric derangements is another important factor in prophylaxis. The importance of pure air and wholesome hygienic surroundings and bodily cleanliness cannot be overestimated.—*Archives of Pediatrics*, June, 1902.

EDITORIAL.

BIENNIAL MEETINGS OF THE STATE SOCIETY.

As the time approaches for the meeting of the *Homœopathic Medical Society of Pennsylvania*, it will not be inopportune to bring forward again the question whether the present arrangement of having annual meetings is the best. The same considerations which have weight with us in regard to the State Society hold good with equal if not greater force in respect to the *American Institute of Homœopathy*. We think that biennial meetings of the State Society, and the same, or even triennial, for the Institute, would tend to promote their growth and strength as scientific bodies more than does the present arrangement.

Familiarity breeds contempt, and from the annual occurrence of the meetings they cease to be of any special or peculiar importance, scientifically or socially, to a large majority of physicians. The opportunity for being present recurs so frequently, and the year rolls by so rapidly, that trifling obstacles are often allowed to interfere with attendance, which would not be the case were the interval between the meetings longer. Then, with the prospect of being obliged to wait for two years instead of one before the hoped-for pleasure and profit could be enjoyed, greater efforts would be made to grasp the opportunity when it offered.

We know that there are many physicians living off from the highroads of travel, and distant from towns or cities of any size, into whose isolated lives the yearly meetings of the Society come as rays of intellectual and social sunshine, the cheering influence of which they would be loth to surrender. It would not be fair, however, to the Society if the sentiment of a minority of its members were allowed to defeat an otherwise desirable policy.

The main objection to the present annual meeting is that it fosters hasty and superficial work on the part of those who contribute papers.

In the first place, we generally find that the bureaus contain many of the same members each year. This is not only proper to a certain extent, but quite natural. Whoever has had the doubtful honor and pleasure of acting as chairman of a bureau will be able to recall the many disappointments he has met with. After having carefully selected his associates with a view to having a creditable report to present to the Society, as the time approaches he finds, to his dismay, that many have done nothing, regardless of the fact that by their acceptance of a position on the bureau they have virtually pledged themselves to contribute to its success. This pledge evidently does not weigh heavily upon their consciences, or perhaps they do not even recognize it; the only obligation of which they seem to know anything is that on the part of the Secretary to be sure to have their names printed on the programme of the Society. Of course, such do-nothings are soon blacklisted, and the workers come naturally to be relied upon in the make-up of the sections. Hence the frequent occurrence of the same names. In the case of the specialties this is particularly the case. Now, it is difficult for a busy practitioner to produce once, or, if a member of the Institute, perhaps twice a year, to say nothing of possible calls from county societies for papers, an article which shall be original, scientific and practical, at once a credit to himself and to the Society. Where there is manifested great literary activity, and where papers are turned out with a rapidity which makes this statement seem ultra-conservative, it will be found, usually, that there are exceptional conditions existing, leaving out of view the differing degrees of facility of composition. Not every one is so favorably situated as to be surrounded, like the centurion of old, by those to whom he can say "Do this," and he does it; to whom he can entrust the making of examinations and experiments, the collecting of statistics, etc., while he himself, making use of this labor of others, compiles the results and furnishes an excellent article. The ordinary bureau member must do all this work himself, and the consequence is that it is either done not at all, or hastily and imperfectly.

Again, there is not enough of incentive to thorough scientific work. The papers presented are frequently read by title only (probably a wise regulation, in the absence of their authors), or in full to a scant, perhaps inattentive audience; and some, even

of the best, are allowed to fall flat with a "sickening thud," with hardly a word of discussion, except by those faithful ones who are ever ready with a "few remarks," in season and out, to the point, or only as an opportunity for introducing some case of their own, in which, in some unaccountable way, they are reminded. Very often this failure to elicit discussion is the fault of the paper itself, we acknowledge, but just as often it is the result of a desire to get through the programme on schedule time. The paper having been handed in, it is safely embalmed in the *Transactions*, perhaps at a future time to be resurrected by title by some Dryasdust.

Short practical papers are at times presented, and give rise to very instructive discussions, but the full benefit of them is lost by the manner in which they are afterwards treated. Would it not be preferable to have such papers, by order of the Society, printed in one or more of the current journals, where they would reach a greater number and do more good, while the others, the more scientific and theoretical ones, could be printed in the *Transactions*? Would it not be possible, by having the meeting biennial, to obtain a greater number of this latter class of articles, founded upon original research, of which the Society could justly be proud, and which could fitly form the main contents of its *Transactions*?

In answering this question much will depend upon the ideal conception of a State Society which each one makes for himself. If it is to be primarily a social "experience meeting," then the present methods are well calculated to make and to keep it such; whereas, if it is to be a gathering of scientific physicians, the ablest representatives of advanced thought in their profession, then we think other means should be adopted, first and foremost among which we place the lengthening of the intervals between its meetings.

Another advantage of this change would be the avoidance of the constantly-recurring tax upon the members of the profession in the city which is called upon to entertain the Society. As things are at present, it seems as if new and varied forms of entertainment and amusement must continually be thought out and provided in order to invite attendance, and these often appear to be made the main features of the assemblage. Were this feature to be eliminated, we think there would be a general

readiness to have biennial, instead of annual sessions. These could then be devoted solely to the presentation and discussion of papers which should have more than an ephemeral value, and would tend to enhance the dignity of the profession as a whole, and of its representatives in the State Society. It is true the attendance might be smaller even than it is at present, but under the circumstances would that be an altogether unmixed evil? Might not, perhaps, more and others come, induced to do so by the certainty of receiving something worth coming for? Might not the intellectual food offered prove a greater inducement than the present banquets and outings?

There are two sides to this as to every other question, and we cannot deny that to many this policy would be a distinct loss; but, after all, the main thing to be considered is the question how to make the State Society conduce to the greatest good of homœopathy, not to the greatest good of the greatest number of homœopathic physicians. A little thought will prove that these two objects are not necessarily identical.

We hope this subject will be given due consideration by all members of the Society. It is not a new idea, but may find more favor at the present time than on other occasions when it has been broached.

W. H. BIGLER.

THE CLEVELAND MEETING.

THE annual session of the American Institute at Cleveland was a pronounced success in every particular. The attendance was unusually large, and universal interest was displayed in the proceedings by those present. As an example, we may observe that over two hundred members were on hand during the sessions of the Section in Clinical Medicine. The changes made in the by-laws governing sectional meetings we believe to be a great improvement over those of the past; but we do not believe that they go far enough. We would prefer to have seen the Runnels plan passed without amendment. Perhaps it is better that the plan was amended as it was, for, if proven unsatisfactory in any particular, it can be modified in accordance with any shortcomings which may be demonstrated in practice.

The officers-elect, we believe, will reflect credit on our National Association. Holding this view, we are in a position to criticise present methods of the election of officers. As things are now, it is possible for self-seekers to start personal booms. Necessarily, it follows that the Institute is at the mercy of any aspiring candidate who may see fit to thrust himself upon its members. We sincerely hope that some plan may be devised which, without taking the electorate from the members at large, will nevertheless secure for us officers of recognized eminence and ability. Fortunately, we can speak approvingly of the fitness of all candidates nominated at Cleveland; but we may not be so lucky in the future.

THE GENTLE ART OF BEING COURTEOUS: A HINT TO HOSPITAL OFFICIALS.

SEVERAL persons have recently spoken to us in regard to a certain institution of this city, under homœopathic management. It seems that in this particular institution visiting physicians, and laymen as well, are universally treated with well-bred kindness and consideration. Said one physician to us: "I like to take a case to that hospital, because the officials are so courteous; they make me feel that my visit has been a real pleasure to them." Said a layman, while speaking of the same place: "The superintendent quite took me by surprise by asking me to be seated, while he sent a special messenger to the ward to inquire how my friend was feeling." Now, hospital officials have troubles of their own, and cannot be expected to embrace each visitor, nor to shed tears over the sorrows of each inquiring friend; yet, a smile, a softly-spoken word, a look of interest, an offer of a chair—these are some of the things that are quite as useful in the management of any hospital as are hot-water bags. The man who can be discourteous to a fellow-being, distraught by sickness or by sorrow, would probably kick a sick dog out of his path. Either action may be considered a safe indication that, while the man may have evolved considerably, so far as outward form is concerned, from the original monkey, yet his "insides" are still

in their pristine state of bestiality. Many people erroneously suppose that the treatment which visitors receive in the "front" of a hospital is an index of the treatment which suffering humanity will receive in the wards. Such is, truly, not the case. Let it not be understood that we offer the instance mentioned at the beginning of these remarks for the purpose of having the reader infer that the officials of *all* *homœopathic* hospitals have cultivated the gentle art of being courteous, until it has become second nature. We regret to say that all our hospitals are not as kind in their treatment of visitors as is the one especially referred to.

THE TREATMENT OF SUMMER DIARRHŒA.—Kerbey conducts the treatment of summer diarrhœa upon the following principles:

Realizing that we have an infection to deal with, a poisoned child to treat, the way is clear. The intestinal contents must be removed. When the stools are infrequent and contain much mucus and blood, irrigation of the colon is the best procedure. Irrigation should not be done oftener than twice in 24 hours. Normal saline solution is the best irrigating fluid.

For very active cases, those having many passages daily, irrigation does little but disturb the child and increase the irritability of the lower bowel. Here he uses a laxative, giving castor oil the preference (for a child eighteen months old, two teaspoonfuls). When there is vomiting, calomel in one-twentieth to one-tenth grain doses.

Milk must be discontinued. It is useless to trifle with diluting the milk or sterilizing it. A carbohydrate diet must be substituted. Barley water, dextrinized, and flavored with chicken- or mutton-broth, is the best substitute for milk. Ordinarily, the food must be continued for several days; in exceptional cases milk must be withheld several weeks.

Kerbey is opposed to the free use of brandy. In his belief it tends to destroy what digestive powers the child has remaining, and favors the development of renal complications.

Egg-albumen water as a substitute for milk has been abandoned on account of its indigestibility in most instances. Altogether, proteids tend to increase the fever, and there is greater systemic poisoning than in carbohydrate feeding.

Plenty of fresh air and cold sponging are prescribed when there is fever.

Drugs.—Most are disappointing. So long as the milk is continued, all are useless. Bismuth subnitrate has seemed to him the most valuable of the legions recommended. Under rare circumstances opium may be of service. It is indicated when the stools are excessively large and frequent. Dover's powder, $\frac{1}{4}$ to $\frac{1}{2}$ gr. every 3 hours for a child one year, is recommended. Cases running a high temperature, with small, infrequent, offensive stools, should receive no drug whatsoever; here irrigation of the bowels must be employed. In collapse, strychnine may be necessary.—*Archives of Pediatrics*, June, 1902.

GLEANINGS.

URÆMIC APHASIA.—In a paper presented at the recent session of the American Medical Association, Riesman (Philadelphia) offered the following conclusions :

1. Aphasia may occur in uræmia, and is at times the sole expression of that state.
2. It is frequently associated with right-sided motor-paralysis, hemiplegic or monoplegic in character.
3. It may be the precursor of uræmic convulsions or coma.
4. The aphasia is usually of the motor type, but may be sensory. There may be word-blindness and word-deafness.
5. It may be associated with agraphia, even when there is no paralysis of the limbs.
6. It is comparatively frequent in children, particularly in cases of post-scarlatinal nephritis. In adults it may occur in any form of Bright's disease.
7. It is generally transient, disappearing completely. In time it is intermittent, and has a marked tendency to recur.
8. When paralysis is present, the two may disappear simultaneously, usually the aphasia first.
9. The features of uræmic aphasia are, *per se*, not characteristic of the causal condition.
10. The most important diagnostic features are the transitoriness of the aphasia and the presence of other uræmic symptoms and of signs of nephritis.
11. In every case of sudden aphasia the possibility of its being renal in origin should be considered, and careful studies of the urine and of the system at large should be made with this thought in mind.—*American Medicine*, June 21, 1902.

F. Mortimer Lawrence, M.D.

THE EVAPORATION BATH IN TYPHOID FEVER.—Coffin (Philadelphia) states that 22 patients in the Presbyterian Hospital were treated by this method. The technique was as follows: The patient was placed on a blanket, and one layer of absorbent gauze fitted closely to the body-surface. This was sprinkled with water at a temperature of 100°–112° F. An electric fan, situated at the foot of the bed on a level with the patient's body, furnished the change of air necessary to dry the gauze. It was found that the average length of time required to evaporate one pint of water was thirty minutes, and this may be taken as the duration of the baths. Results were, on the whole, extremely disappointing. It may be said that in all the cases of typhoid fever (108) treated in the hospital during this period of three months, those treated by the evaporation-bath method gave the least satisfactory results, as compared

with tubs or sponges, and their course was almost identical with a series of cases in which no hydrotherapy was used. The baths were distasteful to the patients, and, in addition, the entire ward was disturbed by the constant buzzing of electric fans. There was practically no response, except in temperature, the stimulating effect on nervous system and circulation being absent. And, lastly, although the series is somewhat short for comparison, the mortality on the evaporation-bath series is $13\frac{3}{4}$ per cent., as compared with $10\frac{7}{8}$ per cent. in all other typhoid cases treated during the same period.—*American Medicine*, June 21, 1902.

F. Mortimer Lawrence, M.D.

THE VERMIFORM APPENDIX AS A CAUSE OF INTESTINAL OBSTRUCTION.—Summers (Omaha) reports the case of a woman, 52 years of age, who was taken suddenly with symptoms of acute intestinal obstruction. On opening the abdomen in the median line it was found that the stenosis was due to a long vermiform appendix which had encircled the ileum about two feet from its lower end. The end of the appendix had adhered to the mesentery close to the ileum, and curled itself into a constricting ring, completely occluding the bowel.

Relief of the constriction was accomplished with considerable difficulty, and the abdomen closed. The woman recovered.—*American Medicine*, May 24, 1902.

Gustave A. Van Lennep, M.D.

THE NON-OPERATIVE TREATMENT OF APPENDICITIS.—Slowly, but surely, the belief is growing that the majority of cases of appendicitis can be successfully treated and cured without surgical interference. And now we shall be prepared for the spectacle of enthusiasm running away with judgment and common sense. If we look at this matter of appendicitis calmly, and with the proper anatomical knowledge of the organs and tissues involved; if we take care to examine our cases critically; if we are fully alive to the possible catastrophes that follow the withholding of operation till too late in cases in which surgical interference is needful, we shall not easily escape the conviction that appendicitis is sometimes a problem for the physician, and at other times a problem for the surgeon. Therefore, we have always felt, and we still feel, that safety lies in the concurrence of the medical and surgical attendants. The combination of an intelligent physician and a conservative surgeon is admirable under all circumstances. There is much safety in the treatment of an appendicitis as it would be ordered by such a council. That's how Dr. Burr feels, too. He related an interesting case of appendicitis, in *The Critique* for February 15th, in a girl aged twelve and a half years, who had been treated by another doctor for menstrual colic. This misguided man had given her emenagogues, and had relieved her colic by hypodermics of morphia. When Dr. Burr reached the case, the temperature ranged between 100 and 105. The iliac region was swollen and very sensitive. She had frequent diarrhoeic stools, attended by escape of much gas. Dr. Burr called in consultation a conservative surgeon, who, having confirmed the diagnosis, also advised that the case be continued upon the same treatment as Dr. Burr had begun. The treatment consisted of hot applications, copious hot water enemata, a diet of mutton broth and milk, and the administration of belladonna, bryonia and rhus tox., according to the prominent indications. These are probably the

most useful, that is most frequently indicated, of all our remedies. One must never overlook the importance of a restricted diet in such cases. Only such foods should be allowed as do not leave a residue in the intestinal canal. Meat broths or peptone preparations are probably preferable to milk. Better underfeed during the acute attack than overfeed. A good prescriber ought never feel obliged to resort to morphia for the relief of the pains of appendicitis. Belladonna, low, will often relieve these pains. After all, the safest plan in appendicitis is to call in your surgeon early, and then to treat the case according to its indications. If it is a medical case, no conservative surgeon will advise immediate operation. If the problem is already a surgical one, no intelligent physician will ask that it be treated medicinally.

O. S. Haines, M.D.

CHLORIDE OF CALCIUM IN HÆMORRHAGIC METRITIS.—Prof. G. Gross, of Nancy, France, in four cases of hæmorrhagic metritis who were under his care, as well as in one case of inoperable cancer of the uterus, where the hæmorrhage persisted in spite of curetting, employed the chloride of lime, with good results. He has an enema administered every day, containing ten gms. of the chloride to two hundred gms. of water, after the rectum has been previously emptied by a clyster. Internally, he gives : Chloride calcium, 4.0 ; syrup peppermint, 30.0 ; distilled water, 90.0. A teaspoonful every two hours. This remedy may be continued for some time, without inconvenience, if the kidneys be normal.—*La Semaine Medicale*, No. 22, 1902.

Frank. H. Pritchard, M.D.

FIVE CASES OF EXTRA-GENITAL CHANCRE.—Prof. Haslund, of Copenhagen, recently presented five interesting cases of these chancres before the Danish Dermatological Society.

The first was a fourteen-year-old girl, who was wholly ignorant how she had become infected. Two months and a half previously she had noticed an eruption (papular) on her body. When seen, she presented an extensive papular eruption, with generalized adenitis, mucous patches on her tongue, and epithelial thickening in her fauces ; her genitals were not affected and her hymen intact. In searching for the primary lesion the right glands at the angle of the right lower jaw were found to be three times as large as the opposite, and the right tonsil much larger than the left, with greatly thickened epithelium ; there was no difference in consistence.

The second case was that of a servant of seventeen years, who could give no date with regard to the source of infection. It was not a case of syphilis in-sontium, for her hymen was lacerated and she had gonorrhœa. On the upper part of the right tonsil there was an ulcer which extended up into the tonsillar niche and over onto the anterior pillar of the fauces ; its floor was uneven and the borders well defined, while it felt infiltrated. The corresponding lymph-glands were larger than normal ; there was generalized adenitis, but no eruption yet apparent.

The third case was a married woman of fifty-three years, with induration of the third phalanx of the third finger, and decided enlargement of the left cubital glands. No secondary symptoms. She had become infected by intercourse with her husband, who for fourteen days had been in the hospital with syphilis.

The fourth case was that of a girl of four years, who entered the hospital with generalized adenitis, regional papula-roseolar syphilide, hypertrophic

mucous patches about the anus and genitals, papules in the mouth and fauces, great hoarseness, leucoderma of the skin of the neck, and signs of a former eruption. On the vola of the right hand was an infiltrated scar of an ulcer of the size of an almond, while the axillary glands were larger and harder than normal. The mother related that months before, the child had burnt its hand on a hot stove, leaving an ulcer which had been very slow in healing. This had probably become infected.

The mother of this child entered the hospital with five large indurated ulcers of the face and under the chin; there was enlargement of the retro-maxillary and submaxillary glands, generalized adenitis, and a roseolo-papular eruption, with excoriated papules on the labia majora. Her disease was thought surely to be due to her child, whose syphilis was of much older date. The woman's husband, who was a drunken brute, and often beat her, had scratched her face, and the excoriated spots were infected by the child. The mother, who in her misery after such a belaboring, probably took the child up in her arms, and the child, with mucous patches in its eyes, nose and mouth, probably carried the virus to these sores. How the child had become infected is unknown, for the husband himself, who was examined later, was free from signs of the disease.—*Hospitalstidende*, No. 18, 1902.

Frank H. Pritchard, M.D.

A CURIOUS EXAMPLE OF FOREIGN BODY IN THE RECTUM.—Dr. Neermann related another case of foreign body in the rectum, which is somewhat curious. An old drunkard of seventy-six years, who, claiming that when suffering from diarrhoea he was afraid that he would soil the bed, had placed an old coffee-cup against his anus. Of a sudden, during an attack of coughing, the cup disappeared into the rectum. Thirty-six hours later, finding himself suffering a great deal of pain, and bleeding from the rectum, he called a physician, who found the cup, with the opening looking towards the anus, about four or five cm. above the sphincter. Chloroform was administered, but on account of threatening asphyxia posterior rectotomy was done under local anaesthesia with ethyl chloride. The cup, with the handle broken off, was extracted, though the necessary manipulations in withdrawing it broke the edges somewhat. The cup measured about six and a half cm. in height and breadth at the mouth, and about four cm. at the lower portion. The wound healed by first intention.—*La Semaine Medicale*, No. 21, 1902.

Frank H. Pritchard, M.D.

TREATMENT OF TUBERCULOSIS OF THE EYE.—Prof. W. Koster has treated with success two cases of tuberculosis of the iris by injection of air into the anterior chamber of the eye. He employs a hypodermatic syringe which has been filled with air passed through sterilized cotton. The needle is introduced, the fluid withdrawn, and holding the syringe obliquely, so that the fluid sinks down towards the plunger, the air is injected. The first case was that of a young girl with a tuberculous iritis. After three injections of air the media cleared up so that vision was $1/2$. The second patient presented a grayish tumor of the iris, which filled the anterior chamber, and which had been wholly uninfluenced by the usual therapeutic measures. Six injections of air brought about its disappearance. Prof. Koster also employed this method in a case of parenchymatous keratitis, with tuberculosis of the con-

junctiva of the eyeball. The ordinary measures had been without effect, but four injections led to a complete recovery.—*Hospitalstidende*, No. 20, 1902.

Frank H. Pritchard, M.D.

HOW MAY ONE DETERMINE IF AN ACUTE SEROUS PLEURITIS BE TUBERCULOUS OR NOT?—Prof. Dieulafoy, in a recent clinical lecture, discussed this point and passed in review the various diagnostic measures which may be of service. Intraperitoneal inoculation of the pleural exudate in guinea pigs, though uncertain, may be done. Great quantities of the fluid, about 20 c.c., should be injected, in order to increase the chances of infection, for the bacilli are few and far between in this fluid. Injection of tuberculin he mentions to condemn. Cultures may give information. He advises glycerin-agar, with addition of sterile rabbit's blood; several glasses with broad surfaces should be prepared. The colonies will develop in three to four weeks. The diazo-reaction he does not regard as of importance. Serodiagnosis, though it is a delicate test, has given him valuable results. He has obtained positive results in the benign cases; less often in those complicating serious pulmonary affections. But above all would he attach the greatest diagnostic value to cytodiagnosis. This method is based on the fact that when a pathogenic agent attacks tissue, certain cellular elements react: they take up the fight and defend themselves; but it is not always the same cells which react. There is a certain "cellular selection." In exudative pleuritis one may, by examination of the fluid exudate, gain certain knowledge as to their origin. A little fluid is withdrawn by means of a sterile syringe and centrifuged. The precipitate is prepared on cover-glasses and colored by either thionin, eosin-hematin, or Ehrlich's triacid stain. One will then detect red blood-corpuscles, polynuclear leucocytes, large mononuclear cells, lymphocytes and endothelial cells. Red blood-corpuscles are found in nearly all pleuritic exudates, the other cellular elements in varying proportion in other forms of the disease. Widal and Ravaut have set forth three varieties of pleural exudate judged by the cellular contents:

1. Pleuritic exudates in patients with heart disease, cancer, and exudates due to compression or irritation of neighboring organs. Here there is no infecting material, no cellular struggle, and the fluid is rather a transudate than an exudate. Therefore, there are no lymphocytes, no polynuclear cells, but nearly entirely endothelial cells, often in large flocculi on account of the active desquamation. This decided desquamation is characteristic of such mechanical pleuritis, and excludes tuberculosis. If the disease and exudate have existed for a long time, lymphocytes may be detected; but the presence of the numerous endothelial cells is sufficient for a diagnosis.

2. Acute infectious pleuritis of streptococcic, pneumococcic, or typhous origin is associated with a lively cellular reaction, and polynuclear and mononuclear cells are in predominance, with few endothelial cells.

3. Acute pleuritis from cold, which most often is of tubercular origin, nearly exclusively present lymphocytes and red blood-corpuscles, so that the microscopic picture is very characteristic of tuberculosis of the pleura; if polynuclear cells are found, they are but scanty in number and due to secondary inflammation. Endothelial cells are rare.

Dieulafoy lays great stress on this method of examination, because it is easily and quickly carried out and is free from danger. It may also be em-

ployed in examination of exudates in the peritoneal cavity. This picture given is characteristic of acute tuberculous pleuritis; but where the disease has followed and complicated old tuberculous processes in the lungs of some extent, this same microscopic picture may be found, but it is *not so constant*. Cyto-diagnosis does not, however, enable one to decide if the disease be a primary acute tuberculosis or if it be dependent on a little focus in the lungs. Prognostically, this would be of the greatest importance, for the outlook is much better in the former than in the latter case. As to therapeutics, he asserts that, as to thoracocentesis, one should be led by the size of the exudate, and not by the condition of the patient; and, above all, not by the degree of the dyspnoea. If the quantity of fluid be large, over 1500 c.c., one should evacuate it, even if the patient's condition does not seem to warrant it. If it be allowed to remain, one runs a risk of sudden death. Dieulafoy has been able to collect over forty such cases of sudden death in those with large and untapped exudates. Even after it has been evacuated, one should examine the patient carefully from day to day, for especially in these tuberculous cases may the fluid be rapidly formed again, and lead to sudden death when least expected.—*Hospitalstidende*, No. 21, 1902.

Frank H. Pritchard, M.D.

CHLORAL IN OBSTETRICS.—Dr. Wislocki has found this drug of service in the irregular and unavailing contraction-pains in nervous and exhausted women in childbed; he advises it in doses of 1.0 (grs. xv.). Often one single dose is sufficient to bring about a state of slumber, which, if it does not occur, may require the drug to be repeated once or twice again. The patient, tired and exhausted, sleeps between the pains, which become more regular and stronger, and labor progresses, for the pains are of some service. He has employed this measure for twenty years in such cases, and can only praise it.—*Przegląd Chirurgiczny*, tom. V., zeszyt 1, 1902.

Frank H. Pritchard, M.D.

PARTIAL INTESTINAL OCCLUSION TREATED BY ESERINE.—Dr. Packard asserts that there is a particular form of partial intestinal occlusion which is recognized by intense distention of the abdomen, due to retention of gas, and which is capable of causing serious disturbances of breathing and of the heart's action, though the patient may have several passages each day. The presence of fluid fecal matters in a U-shaped coil of intestine suffices to prevent the passage of gas if the peristaltic movements are not strong enough to force it onward. Giving cathartics does not help matters, for they only increase the intestinal secretions and augment the quantity of contents of the intestinal tube and the resistance to be overcome. On the contrary, eserine as recently recommended by Prof. v. Noorden, of Frankfort-on-the-Main, for intestinal atony, he has found to be especially useful. He uses generally the sulphate or the salicylate, in a dose of 0.0004–0.0012, repeated twice a day, or, if necessary, every four hours. With this drug he has succeeded in several such cases.—*La Semaine Médicale*, No. 24, 1902. (The article by Prof. v. Noorden is abstracted in the January number of the *HAHNEMANNIAN MONTHLY*, 1902.)

Frank H. Pritchard, M.D.

EPICARIN IN SEBORRHOEA OF THE SCALP WITH FALLING OF THE HAIR.—Dr. F. Winkler recommends this drug in falling of the hair due to seborrhœa

of the scalp, in the following formula : epicarin, 5.0 ; sulph. ether, 15.0 ; spir. vin. gallic., 80.0. A few drops to be rubbed into the head, once a day ; if used too often or too much the hair will become brittle. In erythematous and ulcerated chillblains he advises a salve of the drug : epicarin, 3.0 ; sapon. vir. kalin., 0.5 ; ung. caseini, ad 30. Rub in once a day after a warm bath. In lichen ruber the itching is quieted by the drug in an alcoholic solution or in salve.—*Centralblatt fuer Chirurgie*, No. 23, 1902.

Frank H. Pritchard, M.D.

TREATMENT OF GLANDULAR TUBERCULOSIS.—Dr. Ch. Willems recommends in the first stage of tuberculosis of the lymph-glands, with brawny infiltration, the local application of a 10 per cent. iodoform-collodion. If the mass does not become smaller and more movable under this treatment in a few days then caseation is under way. By deep fluctuation one may detect central softening and breaking down in the gland. A sharp bistoury is thrust into the mass and a short drainage-tube inserted. The skin contracts and draws in over the gland after the softened contents have been squeezed out through the tube. Dress with iodoform-gauze and absorbent cotton, using some compression. Remove the dressing in a few days ; keep the neighborhood of the opening very clean and antiseptic to prevent mixed infection. Leave in the drainage-tube for three or four weeks. If the gland be only one of a mass of enlarged ones, the neighboring ones will also decrease in size, especially if one apply the iodoform-collodion to them. If the glands suppurate then, the same treatment is required, though the tube must be left in longer. If softening be extensive and fistulæ form, each opening must be drained. Softened foci which have not opened should be incised with the bistoury and drained, and now and then iodoform-collodion should be applied. In this manner one may bring about healing without leaving disfiguring scars. He would only extirpate in those cases where the skin is thinned, the fistulous opening irregular and ragged, leading into a pocket, coated with tissue of a pork-like appearance.—*Centralblatt fuer Chirurgie*, No. 21, 1902.

Frank H. Pritchard, M.D.

HOW TO FEED THE PATIENT IN ULCER OF THE STOMACH.—Prof. Lauder Brunton thinks that one should use the same care in treatment of ulcer of the stomach as in one of the skin, withholding all irritating substances, both mechanical and chemical. Therefore, he begins by giving such patients rectal feeding for several days, then commencing carefully to give milk, mixed with lime water, by the mouth, at the same time keeping up the rectal feeding. Allow but little milk at a time and well diluted, for if given too abundantly it may coagulate in great, soft masses, and do mischief. If this be tolerated, one may go over to a porridge of egg and milk, from that passing to a very finely-bruised preparation of fish, crushed in a mortar. If this agree, then one may try chicken-meat, rubbed up in the same manner. At the same time, if this diet be well borne, one may permit chocolate to be drunk, to relieve the monotony of the diet. Soon one may begin to give other food. As to bread, that which is old is the best, for it is most easily digested. Beef yields the coarsest fibres, chicken the finest. The food should be very finely chewed, and this should be emphatically impressed on the patient. This holds particularly true of cheese, which is not so hard to digest as is customarily held, if it be well masticated. All foods containing a great

deal of cellulose, as currants and raisins, as well as fruit-stones and seeds, as well as fish bones, should be very carefully left out. At the same time, chemically, hard and firm food may do harm by causing a too great formation of HCL.—*Hospitalstidende*, No. 18, 1902.

Frank H. Pritchard, M.D.

ATROPINE IN OBSTINATE CONSTIPATION.—Dr. Mansbach, at a recent meeting of the Nuremberg Medical Association, reported a case of obstinate constipation of eight days' duration which was relieved by hypodermatic injections of atropine, 0.0015 in all. The case was that of a laborer of nineteen years, who came under observation with violent pains in the ileo-caecal region: pulse, 72; temp., 36.5. He was given calomel, high injections of soap and water and glycerine rectally, without relief. The next day, temp., 37.7; pulse, 132; vomiting of bilious matter, though flatus was passed. Atropine was injected twice in doses of 0.00075. Three hours later he had two copious passages. The following day a swelling could be made out in the ileo-caecal region. The further course of the case was one of an afebrile perityphlitis.—*Muenchener Medicinische Wochenschrift*, No. 21, 1902. (I have found this drug to be very reliable in such cases, as well as in those of intestinal obstruction from paralytic ileus. It is well worth a trial in incarcerated hernia as well. I have found in these latter cases a hypodermatic injection of morphine and atropine will be a useful aid.)

Frank H. Pritchard, M.D.

TYPHOID FEVER WITHOUT INTESTINAL PHENOMENA.—Dr. Blumenthal, of Berlin, at a recent meeting of the Association for Internal Medicine of that city, reported from the Urban Hospital the case of a pregnant woman of twenty-three years who fell sick with all the typical signs of typhoid fever. She also presented Widal's sign. Unfortunately, she aborted and died on the twentieth day of the disease. The post-mortem did not reveal the slightest ulcer of the intestine, but only a hæmorrhagic and follicular enteritis. Typhoid bacilli were detected in the spleen. In the discussion, Prof. Litten said that he had reported six such cases where the diagnosis anatomically was made from the other findings of post-mortem. The fever, in typhoid, is not necessarily due to the intestinal involvement, but may be dependent on the general infection. Prof. Fuerbringer though admitting that "dry typhoid," typhus siccus, which may run its course without diarrhœa, is by no means infrequent, says the absence of findings in the intestines is very rare. It may be explained by saying that the disease has "jumped" over the first stage, that of the intestine, or that the ulcers have already healed. Prof. A. Fraenkel was of the opinion that when a typhoid goes on to death, without complications, but few ulcers will be found in the intestines. Besides that, the etiological unity of typhoid has been very sorely shaken of late by detecting in the blood of typhoid patients other bacilli. Prof. Baginsky called attention to the fact that with typhoid in children, both clinically and anatomically, the intestinal phenomena are but little pronounced to which in earlier years the favorable course was attributed. The septic symptoms cause the fever and lead to the frequent abnormal deviations and recurrences.—*Berliner Klinische Wochenschrift*, No. 22, 1902.

Frank H. Pritchard, M.D.

SOME RECENT LITERATURE ON INTESTINAL PARASITES.—Dr. Feruccio Schuppper reports the case of a woman of twenty-three years who, after a feverish attack which suddenly appeared, was given quinine. She being pregnant, of course she aborted, and continued to flow profusely. About twenty days later her temperature was intermittent; later continual, which, with a tendency to daily intermissions, persisted for two weeks longer, with typhoid symptoms: distention of the abdomen, enlargement of the spleen, coated tongue, a roseolous exanthema, etc. Towards the end of the third week, after the temperature had again become intermittent, the fever left her after a great number of ascarides had been expelled.

Though he would not attribute the affection to the worms, yet in weakened individuals their presence in the intestines would favor infection by the bacterium coli, as well as increase their virulence. The symptom-complex described by Chauffard as a "lumbicosis of a typhoid form," therefore, is to be regarded as a coli-bacillosis, or as one of the fevers described by Heubner as of gastro-intestinal origin.—*Gazetta Degli Ospedali*.

Dr. Papi, in a child of eighteen months, with remittent fever, diarrhœa and cough, who was under treatment, observed the appearance of a type of breathing resembling the Cheyne-Stokes. The mother said that the day before the child had vomited a round worm. An anthelmintic was given, and twenty-seven such worms expelled, after which the symptoms disappeared. This peculiar type of respiration was due to a substance produced by the parasites, which acted upon the respiratory centre in the medulla.—*Ibidem*.

Dr. Prospero Dematteis asserts that cases of grave anæmia and blood-dyscrasias may at times be due to the presence of worms in the intestines, whose toxins are absorbed by the host and poison him. He has demonstrated that by injections of watery extracts of the liver of ascarides one may produce in rabbits fatal poisoning. The active movements of the ascarides may produce lesions of the intestinal mucous membrane and favor this absorption. With tænia this does not hold good, though they may be present simultaneously with tapeworms. In febrile conditions the increased temperature excites the worms to greater activity, so that even perforation of the gut may ensue.—*Ibid.*

Dr. Schwankhaus reports the case of a boy of thirteen who suddenly developed the symptoms of a general peritonitis from a perforated appendix. Dying twenty-four hours later, a purulent peritonitis was found post-mortem. A large female round worm was discovered between the perforated appendix and the peritoneal cavity. In the appendix there also was a fecal stone.—*Wiener Medicinische Wochenschrift*, No. 20, 1902.

Frank H. Pritchard, M.D.

ON OPACITIES OF THE CORNEA CAUSED BY LIME, AND A METHOD OF CLEANING THEM.—From the elaborate monograph of Andreae we learn that the opacities of the cornea caused by lime must be an organic combination, viz., albuminate of calcium, for which we have no solvent. But such a solvent has been found in chloride of ammonium, which has been employed successfully in 2 to 20 per cent. solutions by means of eye-baths applied for one-half or three-fourths of an hour daily, at first on the eyes of oxen, then on living rabbits whose corneæ had been cauterized with hydrate of calcium, and finally on a man with an opacity, due to lime, of a year's standing.

For general use he advises 2 per cent. solutions, which are not irritating. His conclusion is that the solution of albuminate of calcium in the living human eye is possible, and thus a new field for ocular therapeutics has been gained.—Dr. H. Guillery, *Arch. f. Augenh.*

William Spencer, M.D.

ELECTROLYSIS FOR PANNUS.—L. Lor, of Brussels, has been applying electrolysis directly to the cornea in cases of pannus due to trachoma, and he reports favorable results, even where the cornea was in an irritated condition from the acute stage of vascularity. Electrolysis has been previously used by many oculists for trachoma granulations, but M. Lor is the first to apply it direct to the cornea in pannus. His method is as follows :

The patient is anæsthetized to the surgical degree, and conjunctival granulations are first removed ; then, always with a current of two or three milliamperes, the positive pole is applied to the cheek on the same side as the diseased eye, and after this is fixed with a clamp, the operator proceeds slowly to pass the comb of the instrument around the cornea, circumscribing the pannus in all its extent, and destroying the perikeratitic tissue for a distance of perhaps three or four millimetres. The same process is repeated one or two times, according to the degree and thickness of the infiltration, until the episcleral layer is reached. Then the comb of the instrument is passed two or three times very lightly over the cornea itself, and over the whole area of the pannus, with careful attention to touch the blood-vessels which pass in the superficial layers of the cornea. Then, after washing the eye, a little vaseline is introduced between the lids, and a simple dry dressing is applied, which may be removed the following day.

The results of this operation are always very benign, and the patient does not hesitate to open his eyes. It is usually necessary to drop a little cocaine into the eye to quiet the pain and the photophobia which may be present during the first few days after the treatment. The region where the electrolysis was applied is slowly invaded by scar-tissue, at the same time that the cornea takes on slowly a lustre and a transparency almost equal to the normal before the inflammation began. On the whole, this treatment gives prompt results in this form of pannus.—*Med. Rev. of Rev.*

William Spencer, M.D.

AN HISTORICAL POINT IN THE OPERATION FOR STRABISMUS.—Antonelli, of Paris, has written a critical digest of the history of the connection of John Taylor with the operation for strabismus. The author states that while surgical intervention for correction of the squinting eye was first mentioned by Taylor in the *Mercur de France* for June, 1737, yet Taylor limited the operation to a slight division of the conjunctiva and capsule, at the same time covering the normal eye, and thus obtained fixation of the operated one. He pretended to cut a nerve filament which functioned the overacting muscle, and thus weakened the muscle and established equilibrium.

Antonelli also states that Taylor never thought of tenotomy or any rational operation for strabismus, of whose pathogenesis he had but an imperfect and disordered conception. Finally, he states that Taylor's famous operation was, in reality, merely the proceeding of a charlatan ; neither the first, nor, unfortunately, the last in the history of medicine.—*Archives d' Ophthalmologie.*

William Spencer, M.D.

THE SIGNIFICANCE OF ALBUMINURIA DURING PREGNANCY.—It has been frequently said of the albuminuria of pregnancy: Mere albumin alone, without other signs of kidney disease, is not alarming. Look for casts and other evidences of renal disease. If we can draw conclusions from the following report, mentioned by H. M. Bascom, M.D., before the Illinois Society, mere albuminuria is alarming. Dr. Bascom reports *ten* cases,—one occurring early, the rest later during pregnancy. In none of these cases were casts found. Nine had eclampsia. Seven were fatal. Does it not look, from this, as if it were better to empty the uterus, and so relieve the kidneys?

THE DIAGNOSIS OF MITRAL INSUFFICIENCY WITH BROKEN COMPENSATION.—Satterthwaite (New York) states that the three cardinal signs of mitral insufficiency are: (1) a systolic murmur at the apex conveyed to the left; (2) accentuation of the second pulmonary sound; (3) increased transverse dullness of the heart. In and after breaking compensation the diagnosis must be based upon the previous history, because the abnormal transverse dullness may be the only one of the three cardinal signs left. If stenosis coexist, as it does in from 70 to 80 per cent. of the cases, we may expect a systolic thrill near the apex in from 15 to 60 per cent., and a presystolic murmur in from 10 to 30 per cent. at least. In children or young people there may be bulging of the precordia.—*N. Y. Med. Journal*, July 12, 1902.

F. Mortimer Lawrence, M.D.

CARBOLIC ACID IN THE TREATMENT OF TETANUS.—Kellogg (New York) argues strongly in favor of carbolic acid as a remedy for tetanus, offering the following points in its favor:

1. Actual figures indicate as many cures from the use of chemical agents as from antitoxin.
2. The use of phenol does not contraindicate the administration of antitoxin.
3. There are no exact methods of measuring tetanic antitoxin.
4. The antitoxin of tetanus is not destroyed by carbolic acid solution.
5. Inasmuch as the antitoxin is not a stable article, we are not justified in continually saturating the system (which would appear essential) with this agent, of which we know comparatively little. On the other hand, of carbolic acid we know considerable, and we have a definite and exact reliable method of ascertaining its action and the extent to which it should be used.
6. Investigators have failed to cure infected animals, even with immense doses of the antitoxin.
7. Cases have been treated alternately, first with the antitoxin and then with phenol, with more satisfactory results during the administration of the latter.
8. Three cases have been treated in New York recently with antitoxin, with three deaths.—*N. Y. Med. Journal*, July 12, 1902.

F. Mortimer Lawrence, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

CONDUCTED BY O. S. HAINES, M.D.,

with the collaboration in German literature of C. Sigmund Raue, M.D.

INDICATIONS FOR ALUMINA IN LOCOMOTOR ATAXIA.—*The Homœopathic Advocate* for January contained an excellent materia medica lesson upon alumina, from the pen of Dr. J. T. Kent. This journal is one that should not be overlooked by those homœopathic physicians who are especially interested in materia medica and therapeutics. We have culled from this paper a group of symptoms that we think will be of service in the proper selection of alumina for that dread disease—locomotor ataxia. This remedy should be useful in retarding the progress of ataxia, even if it is incapable of curing that affection.

Alumina seems to affect the whole spine ; it produces *weakness* of muscles, of limbs, of rectum, and of bladder. It produces disturbances of co-ordination ; the whole state looks towards a paralytic breakdown. The conditions to which this remedy are homœopathic are not acute. They are slow in coming on and slowly progressive. Vertigo appears prominently. If the patient closes his eyes, he totters and falls if not held firmly. He cannot walk with his eyes closed, nor lean over. Numbness and tingling is associated with the paralytic tendency. Tearing, rending pains, that resemble the fulgurating pains of ataxia, are present in both upper and lower extremities. The urine either flows very slowly, or dribbles. Even soft stools are passed with difficulty. With all, there is an increasing debility, loss of flesh, loss of muscular power, loss of memory and of intellectual power. The author warns us to be careful that we have not only the particular symptoms present in the different localities, but especially those general symptoms which are peculiar and characteristic of the alumina patient, as an individual, if we would expect its full curative influence. There can be no doubt but that much discredit is cast upon homœopathic remedies by the slipshod method of their selection. We should like to read some *clinical experiences* favorable to the action of alumina in locomotor ataxia.

SOME REMEDIES FOR SOUR STOMACH.—The title "Sour Stomach" hardly describes Dr. Nash's readable little article in the *Hahnemannian Advocate*. He differentiates a number of remedies that he has found most useful.

Sulphuric acid has been curative, first, in marasmic children, with sour stomach, sour vomiting, and a general scur condition. The child smells sour despite great care in regard to cleanliness. Second, in greatly weakened, cachectic subjects, who complain of a sense of weakness and internal trembling.

Such cases are very apt to have indigestion and sour stomach. Third, in old topers. This remedy has done wonders for the stomach troubles of whiskey-drinkers. Natrum phos. is also useful. It has a tongue coated thickly yellow at the base. It will sometimes succeed where one would be led to think of rheum or sulphuric acid. Phosphorus is a royal remedy in sour stomach. It goes deeply, and is especially called for in chronic cases. The affection may range from a simple acid condition to the worst malignant form of stomach disease. There may be vomiting of many kinds and colors. The weak, hungry feeling in the stomach, the desire for very cold articles, and the vomiting as soon as they become warm in the stomach, are valuable indications for phos.

LACHESIS, RHUS TOX., MELILOTUS—THERAPEUTIC NOTES.—Dr. G. W. Bowen makes some very remarkable statements regarding these remedies with a positiveness that is startling. He finds that lachesis will prevent or cure catalepsy. During the past four years it has saved three persons from being buried alive. One of these was a child that had been under the water for half an hour. Another had lain in a coffin for two days, waiting for the day of funeral. What do you think of that? Of rhus tox., he remarks: "It has cured all burns of any kind for me." The doctor applies it in a solution externally. The one-tenth tincture is diluted with three parts water. It is the only remedy he uses for frosted feet. Of melilotus, he has this to say: "One dose of the first centesimal dilution cures or relieves almost every sort of headache. It will stop epistaxis in one minute. It will cure spasms of any kind, epilepsy or eclampsia, in one or two minutes. It cures almost immediately congestions in any part—head, chest or ovaries. In large doses it is dangerous, and has caused abortion." Dr. Bowen does not tell the whole truth, however, when he says of coffee: "It does not stimulate; it sustains the whole system; and will do this better than anything I know of in this world." Or, again, when he affirms that oatmeal is a curse to the people: "It has been the principal cause of all cases of indigestion, dyspepsia and internal disturbances that are so much more common of late years, and which call so frequently for the use of digestive tablets." (Quoted in *American Physician*, from N. I. and S. M. Hom. Med. Association, 1902.) The author can back up these experiential statements by a practice of fifty years!

POST-PARTUM HÆMORRHAGES.—In his paper upon this subject, read before the Illinois Homœopathic Medical Association, Dr. C. A. Weirick defines his position by saying that "the flow of blood from the reproductive organs is abnormal, following labor, when the quantity of fluid escaping is sufficient to produce exhaustion." He deprecates the twisting of the membranes after the placenta has passed the vulva. One is very apt to tear off a piece of membrane by this procedure. A better plan is to press the uterus down with one hand upon the abdomen; and, with two fingers of the other hand inserted into the vagina, guided by the membranes, follow it to the end and remove it intact. Among the reflex aids to uterine contraction is the old one of putting the child to the breast. The most potent means is the injection of warmed water into the pudenda; usually, just above the clitoris. This is very easily carried out, and is very efficient. The essayist mentions three remedies: ergot, trillium and cimicifuga. The first he uses hypodermatically. Trillium he gives in doses of ten drops, tincture. Violent, irregular contractions, call for cimicifuga.—*Med Visitor*.

TREATMENT FOR EXUBERANT GRANULATIONS.—Of course, this is a trivial condition in the estimation of physicians, but in the eyes of the laity, "proud flesh is quite a bugbear." Recently, during a conversation with Dr. O. C. Brickley, of York, Pa., we learned that the doctor had used nitric acid, in weak, watery solution, for many years, as an application for those ulcers in which epithelial reproduction around the edges of the wound did not keep pace with the growth of granulation tissue. As a result of such failure we have excess of flabby granulations rising to a height above the level of the granulating surface. Such cases are tedious. Cutting away the granulations does not always cause prompt healing. We noticed during the epidemic of vaccination the past winter that a number of cases developed large ulcers from sloughing of the integument. These cases were vaccinated with every precaution, and only the "best" virus was used. Some of these ulcers healed very slowly, and were covered with exuberant granulations. One young woman returned to me some four months after she had been vaccinated, showing an unhealthy ulcer the size of a silver dollar, that refused to heal. I applied Dr. Brickley's remedy upon plain gauze. The effect was most excellent. One week sufficed to heal it completely. Since then it has become a favorite application with me for such cases of exuberant, unhealthy granulation tissue. Pressure made with a bandage helps the cure along. I acidulated distilled water with pure nitric acid, until it tasted sharply acid, and applied pads of plain gauze soaked in such a solution.

SUPPRESSED GONORRHOEA.—S. E. Chapman relates the case of a man who had been cured of a discharge from the urethra by local means. The case was, presumably, gonorrhœa. He complained of pains in his groins, extending into the testicles; general muscular soreness, and stiffness and lameness of the joints. Paraphymosis was present. The author does not tell us whether the discharge contained gonococci, nor whether the man was suffering from gonorrhœal rheumatism; but the symptoms mentioned are very suggestive of the conditions. We know how difficult gonorrhœal rheumatism is to cure. The doctor first reduced the paraphymosis by the use of olive oil and manipulation. Then he prescribed medorrhinum 1000, three doses. Within three days a profuse, creamy urethral discharge appeared. He then prescribed placebo. In another week this discharge had almost ceased, and soon the patient was well. This case is interesting, notwithstanding the fact that we lack certain data upon which to base a claim that it was an instance of specific urethritis suppressed, and subsequently cured by internal medication. Doubtless, cases of this latter nature are frequently met with in the practice of homœopaths, and we should like to see more confirmations of this kind, especially those backed up by the results of a bacteriological examination of the discharge.—*June Advance*.

CROUP.—Dr. S. G. Brown speaks enthusiastically of the superiority of homœopathic medication in this common affection of childhood. The following indications he mentions as guides for the selection of the most useful remedies. If the child, after exposure to dry cold, develops a high fever, and then becomes restless and very thirsty; if it tosses about, and these symptoms are then accompanied by a dry, metallic cough, we should give aconite. For croup that comes on *after* midnight, with moist rattling of mucus in the

throat, hepar is more suitable. Spongia, on the other hand, suits a short, dry, barking cough, when the child seems about to strangle. The attack is apt to appear *before* midnight, and the child bends the head backward in order to breathe more readily. In a dark-complexioned child, with a violent, jerky cough that causes cyanosis of the face, and soreness of the throat and chest, we may select iodine by preference. Ipecac. is only useful when there is a choking cough, especially upon falling asleep, strangling, and more or less nausea. The child will be worse early in the evening. Lobelia should be prescribed for a constant, ringing cough, with shortness of breath. The child seems in great anguish, and catches at its throat. Kali bichromicum is useful for those fat, chubby children with a constant, hoarse, barking cough, and also when the mucus is tough and stringy. These are common remedies, and well known to all; yet it is attention to just such differentiating indications that determines whether their use will be followed by success or failure. —*Medical Advance.*

RATIONAL THERAPEUTICS.—The important principles of rational therapeutics, as given by Dr. B. W. Loomis, in his article in *June Advance*, are worthy of notice. One should always bear in mind the self-limitation of a large number of diseases, and hence a policy of masterly inactivity is wise under certain circumstances. The problem of treatment must be kept as simple as possible by the exhibition of few remedies, well selected. Study the *patient* as much as the ailment from which he is suffering. Try to remove the *cause* of his symptoms, relieve pain, and make the patient comfortable. Avoid a large number of remedies, for the reason that they are wasted; they neutralize one another. Prescribe for conditions, not for diseases. Watch for symptoms that may be the effects of remedies previously prescribed. It is often rational to withdraw all medication for a time, administering placebos and watching. (Why, then, Hahnemann must have been a rational therapist!)

QUININE; ITS USE AND ABUSE.—If quinine has not been previously abused in your case, you will find that cinchona, carefully prescribed, will usually suffice. If there is a history of excessive quininism, then the potentized chin. sulph. will act better. If you are using quinine as a remedy and not as a tissue food, you will find that it acts better when potentized. Of course, if we are trying to supply a loss of "quinine tissue," then it must be administered as a food. There are some doctors who seem to think certain ailments and complaints are due to lack of quinine in the human tissues. China is one of the remedies which many homœopaths believe acts only in large doses of the mother tincture. This is not so. China, if indicated, displays its marvelous powers even in potencies as high as the sixth or thirtieth, as we can easily prove. Dr. Lewis P. Crutcher, in *Medical Visitor*, pleads for a recognition of the prominent characteristics of this remedy, and deprecates the common abuse of china and quinine by homœopaths, as well as by those who know no better. Among the characteristics is the well-known "every-other-day" aggravation. The china patient chills easily, and is sensitive to cold. The headaches are aggravated by cold air and after eating. The existence of any drain upon the economy should be remembered, as china relieves the effects of loss of any of the vital fluids. It is particularly useful in the collapse following uterine or intestinal hæmorrhages. The china patient is "a fermenter," the

abdomen is tympanitic, distended. Milk cannot be tolerated. The chill of china is much worse from drinking cold water. The thirst of the remedy comes with the sweat, and not during the chill nor hot stage. The china sweat is profuse and debilitating. Bacon warns the profession against the use of large doses of quinine in cases in which there is any involvement of the mucous membranes of the ear, nose or throat. Deafness may result.

MAMMARY TUMOR : CONIUM.—Dr. E. E. Case reports a tall, slender maiden, aged sixty-one, had a lump the size of a hickory nut in her left breast. It had been noticed three months previously. The lump was sensitive and sore to touch, the whole breast sometimes swollen and sensitive. Leucorrhœa, yellow and acrid, was also complained of, and pains in the back. She received four doses of conium 1000, at intervals of twelve hours. Nineteen days later the lump had disappeared.—*Med. Advance.*

SECALE CORNUTUM IN PUERPERAL INFECTION FROM THE STANDPOINT OF THE TWO SCHOOLS OF MEDICINE.—In the *Allgemeine Homöopathische Zeitung* (June, 1902) Dr. Mossa quotes Prof. Krönig, the Leipzig gynecologist, who is strongly opposed to the vaginal douche in confinement cases, and who discountenances the use of antiseptic intra-uterine douches in puerperal infection on the grounds that they do not reach the sites of infection and are liable to carry with them renewed infection. On the other hand, he strongly urges the use of secale cornutum, in order to cause a contraction in the lymphatic vessels of the myometrium and thus check the further progress of the infection. In conjunction with this mode of treatment he recommends antistreptococcic serum and inunctions of unguentum crude.

Dr. Mossa comments that homœopaths have ever looked upon secale cornutum as one of the most potent remedies in puerperal septicæmia. "No remedy in our materia medica displays such decided tendencies to blood decomposition as secale, and none has a stronger affinity for the uterus. Accordingly, it is just in such conditions as uterine infection in which this remedy is indicated, and on the following symptoms: The abdomen is distended, but not very sensitive; the lochia are offensive and brownish; ulceration about the vagina; high, burning fever, with violent convulsive seizures of chilliness; pulse small and intermitting; anxiety, præcordial pain and vomiting of brownish, offensive material; stools offensive and loose; urine suppressed. The sensorium alternates between quiet apathy and violent delirium." (Bähr.) Dr. Mossa calls attention to the key-note, "Relief from external cold, the opposite to arsenicum." In fact, the true characteristic of this condition is that, while the patient feels cold and the temperature may be subnormal, still she does not want to be covered, and desires all the cool air she can get.

THERAPEUTIC INDICATIONS IN UTERINE MALPOSITIONS.—The *Zeitschrift des Berliner Vereines Hom. Aerzte* (June, 1902) contains an exhaustive article upon uterine therapeutics by Dr. Dahlke, from which the following abstracts are made:

Aloes.—Feeling of heaviness and weakness in the entire abdomen; irritating leucorrhœa. Associated symptoms are hæmorrhoids; loss of confidence in the sphincter ani; morning diarrhœa; rush of blood to head.

Ammon. mur.—Menses too early and most profuse during night. Severe pain in lumbo-sacral region, worse at night.

Arnica.—Recent cases of prolapsus occurring after trauma or heavy lifting.

Aurum.—Prolapsus due to uterine hyperplasia. The prolapse of aloes results from vascular engorgement; that of stannum, from laxity of the ligaments (rhus tox.).

Belladonna.—Recent cases with bearing down.

Calc. carb.—Chronic cases, as a result of lifting. The general indications for calcarea are present. *Calc. phos.* is similar to helonias.

Caulophyllum.—In permitting attacks of bearing down. Similar to puls. and cimicifuga.

Cimicifuga.—Bearing down, accompanied by fleeting, crampy pains. Prolapse without pronounced sympathetic derangements in the nervous system seldom call for cimicifuga. (The uterus is tender to touch when cimicifuga is indicated, and there is almost always vertex, headache, and mental depression.)

Erigeron.—Prolapse, with irritation of bladder and rectum, and menorrhagia of bright blood.

Graphites.—Similar to sepia. There is, however, decreased sexual desire and stasis of the pelvic circulation.

Helonias.—Bearing down; conscious of her womb (*lilium tigrinum*). Menorrhagia and profuse leucorrhœa. Anæmia and debility. (We know of no more potent remedy in endometritis with profuse, irritating discharge.)

Hydrastis.—Prolapse, with erosion of cervix. Thick, yellow, stringy discharge. Pruritus vulva. Emaciation (gone feeling in epigastrium; constipation).

Lilium tigr.—Prolapse, with feeling as if everything would drop out. Pain in left ovary and infra-mammary region. Hyperplasia. (*Lil. tigr.* has proven a valuable palliative in uterine fibroids, with bearing down and hæmorrhages).

Platina.—Prolapse, with hyperæsthesia of the abdomen and genitalia. Menorrhagia; increased sexual desire; dysmenorrhœa; hysterical manifestations.

Sepia.—Bearing down sensation, causing the patient to cross legs to relieve feeling of prolapsus. Liver spots; red sediment in urine.

Ustilago.—Prolapse, with tendency to bleeding, either as menorrhagia or a bloody show between the periods. Downward pressure. Climaxis.

RHEUM IN PEDIATRIC PRACTICE.—N. Franz Hartmann (*Die Kinderkrankheiten*) speaks in the following terms of rheum: "It is hardly necessary to emphasize the efficacy of rheum in children's diseases, as no doubt every physician having any experience in this kind of practice is familiar therewith. Homœopathy does not employ this remedy according to the precepts of the old school: not as a derivative, or an evacuant, but based on a knowledge of its physiological action, as a simile, whereby we not infrequently prove that it annihilates certain affections in their incipency before they have developed to a point where they can be classified, and thereby often averts serious consequences.

"Of what value is this remedy when the child shows excessive pallor; twitches the facial muscles and eyelids; clenches the hands, twists about and cries without apparent cause! Also in difficult dentition; conditions indicating the onset of possibly serious trouble!

"So also we administer rheum with curative results in organic affections in children, centred in derangements of the digestive tract, accompanied by various abdominal manifestations, with puffiness of the face and especially the eyelids; dilated pupils; sopor, and even unconsciousness."

SOME USES OF THE BROMIDES IN NERVOUS AFFECTION.—The primary effect of the usual doses of any of the bromides is to contract the blood-vessels, notably those of the brain and cord. They arrest reflex action and diminish muscular irritability. Thus the organs are placed in that condition of quietude which leads to sleep. The secondary effect, however, during prolonged use, or after suspension, is just the opposite, namely: The contracted arteries dilate, congestion occurs, either passive or active; sleeplessness, nervous erethism, hyperæsthesia of the reflex nervous system, and abnormal muscular irritability results. These pathogenetic effects occur when bromides are administered to healthy animals or men. In choosing a homœopathic remedy, we must take into account both actions of a drug. Thus we may prescribe very minute doses of the bromides for cerebral or spinal anaemia; but in congestion, spasm or erethism, we give more appreciable doses, yet not enough to produce an aggravation of the malady. The homœopathic physician who will use the bromides according to such rules becomes possessed of a class of valuable remedies, without which his success in the treatment of many severe and dangerous disorders would be greatly diminished. Dr. M. E. Douglass, in his article upon this subject, then takes up the bromides of ammonium, camphor, lithium, potassium and calcium, and gives us many valuable points relative to these drugs. The bromide of calcium seems to be the most valuable of its class, in the treatment of children. The child for whom the calcium bromide is most useful may be described as lax-lymphatic, nervous and irritable. It grows rapidly, but flesh is not solid. It learns to walk with difficulty, and its teeth come tardily. Gastric, intestinal and cerebral irritation attend. The drug is also very useful for the vomiting, diarrhoea, sleeplessness and general fretfulness of such children, as well as for the tendency to brain disease. In mild cases, the 1x or 3x may be given, but no danger need be feared from its use in larger dosage. It is not a narcotic like opium. One grain for each year of child's age is not excessive.

The sphere of action of the bromide of camphor is nearly that of camphor modified by the bromine. It is primarily homœopathic to cerebral congestion with great nervous erethism, especially when it assumes the form of hysteria. Dr. S. Weir Mitchell has reported the case of a gentleman threatened with apoplexy who had already had one attack and was hemiplegic. He was seized with numbness, vertigo, headache and thickness of speech. Thirty grains of lithium bromide removed these alarming symptoms within half an hour. It might appear, then, that the bromide of lithium is far more speedy in its action than other bromides. The bromide of potassium was the first preparation of the bromides presented to the profession. And it has been used much and abused much. No remedy compares in efficacy with this, in the night-terrors of children, from any cause. A very satisfactory method of using the drug is to beat up a few grains with a yolk of an egg, and give as an enema. The first or irritative stage of dilirium tremens is ordinarily treated by five or ten grains of this bromide, repeated every few hours. But the face must be flushed, the eyes red, the pulse quick and hard, and the

delirium of an active type, with horrid delusions. If the face is cold and pale, the pulse weak and thready, the bromide of potassium must not be given in this condition. Here digitalis is preferable. These two remedies, aided by *cinicifuga* 3x and *hyoscyamus* 1x, control all cases of this fearful malady.—June *American Medical Monthly*.

THE POST-GRADUATE STUDY OF MATERIA MEDICA.—George T. Shower, M.D., of Baltimore, has some very interesting things to say about the best method of studying materia medica, in *American Med. Monthly*, and claims that the first element in the successful study of materia medica is found in the effort to assure ourselves that there is a sound and rational basis for the varied and often seemingly unreasonable manifestations of drug effects. During the preparation for a medical degree, a mere outline of the action of a series of drugs is all that can be sought for with profit. The student acquires what might be termed a working knowledge. We think students are apt to understand that by "a working knowledge" is meant a knowledge sufficient to enable them to work other people, or upon other people. Such is not the meaning of the expression. It means a sufficient knowledge of our materia medica to enable the student to go on with the study of that branch after he has left his alma mater and embarked on his career. Dr. Shower says, whether we ever progress beyond that stage of knowledge depends upon our industry, conscientiousness and intelligence. Some students simply fall into a habit of routine, coupling a certain group of remedies with a series of morbid conditions. Others try to forestall failure in the future by storing up in their memories a brood of sympathetic preparations, and thus impair their skill in handling our legitimate drugs. Homœopathic therapeutics is a specialty sure enough, and no one can hope to become skilled in this particular department of practice, unless he devotes much time to its study, after he has obtained his medical degree.

SULPHUR.—If the case is one of those scanty in subjective symptomatology, difficult to prescribe for on that account, or a "one-symptom" case, such as a menorrhagia or a metorrhagia without characteristics of flow or modalities, and your remedies do not seem to influence the condition to any great degree, then I should say such a case will likely be helped by sulphur.

DIPHTHERIA.—Dr. Goullon speaks of acidum nitric. as "our specific diphtheria remedy," and uses it in alternation with other remedies,—bell., for example. In the treatment of this dread ailment he insists upon the importance of a *two hours' sweat*. This he considers a *sine qua non* for a favorable course, preventing complications and sequelæ, such as glandular abscesses, croup, paralysis of heart or nerves, and rheumatism.—*Translated—Hom. Rec.*

PAREIRA BRAVA IN RENAL COLIC.—It seems that the dose and method of its administration is important. According to Dr. Sieffert, of Paris, we must, at first warning of an attack, take four drops of the mother tincture. After this, two drops of the sixth centesimal every fifteen minutes. Prompt relief is said to follow this plan. At the same time copious draughts of milk are recommended, if the stomach will retain food or drink. Pareira brava suits a case in which the attack begins with pain in glans penis; this is followed by tenesmus of bladder and rectum, and severe pains down the ureters. These pains are apt to extend *down the thigh*.—*From Hom. Monatsblätter in Recorder*.

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A Medical Newspaper.

EDITED BY

HERBERT P. LEOPOLD, M.D.

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The Eclectic Practice in Diseases of Children. For Students and Practitioners. By William Nelson Mundy, M.D. 12mo., 631 pp. Cloth, \$2.50 net. The Scudder Brothers Co., Publishers, Cincinnati, O. 1902.

The homœopathic practitioner who may find it worth while to peruse this manual on Diseases of Children will be gratified to learn that eclectic practice is good, sound, practical homœopathy, shorn alone of the dosage controversy. Were all schools to lay aside their sectarian pride and accept the precepts of

the only true and rational therapeutics, namely, that based on the law of similars, supplemented by the rule of the minimum dose, there would be no more bad feeling among them. It seems strange that so many physicians practice this way after all, as can be seen from old-school, and especially eclectic works, and yet they will have nothing of the homœopath.

Dr. Mundy gives excellent advice in the therapeutic section: "Never give a dose of medicine unless you see clearly the indication for that particular medicine, and have a reasonable certainty that its action will be beneficial." Also, "In the employment of remedies we find greater success from doing one thing at a time, and, as a general rule, from the use of single remedies or very simple combinations."

The therapeutics is the best portion of the book. The section on feeding is very elementary, and the pathology and symptomatology not salient, and sometimes betraying inaccuracies. The remedies recommended are, as a rule, the ones familiar to us, with occasionally mention of an unfamiliar name or remedy we have never tried. We feel, however, that many of these suggestions should prove practical.

We are surprised to find no mention made of antitoxin in the treatment of diphtheria. In this particular Dr. Mundy is less eclectic than the majority of homœopaths. However that may be, Dr. Mundy has presented his subject well, giving his personal experience in the treatment of sick children.

Progressive Medicine. A Quarterly Digest of Advances, Discoveries, and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., assisted by H. R. M. Landis, M.D. Volume II. June, 1902. Lea Brothers & Co., Philadelphia and New York.

Progressive Medicine differs from all other periodicals, retrospects, digests and year books, in that it possesses an admirable digestive system of its own. In other words, it does not submerge its readers under a torrent of assertions culled at random from medical literature, and often flatly contradictory to each other. Instead, a specialist of unquestioned authority reviews the literature of his own branch, judiciously selects what is valuable, and then presents it with foot-notes indicating the original publication in its proper relation to other advances in similar lines. For example, in the present volume William B. Coley, M.D., discusses surgery of the abdomen, including hernia; John G. Clark, M.D., discusses the advances in gynecology; Alfred Stengel, M.D., considers diseases of the blood and ductless glands, together with hæmorrhagic and metabolic diseases; and Edward Jackson, M.D., contributes a review of progress in ophthalmology. All of the articles are in themselves notable contributions to the literature of medicine, and should continue to insure for Progressive Medicine the place of preference in the library of every medical worker.

The American Institute of Homœopathy.—The American Institute of Homœopathy met in its fifty-eighth annual session in Cleveland, Ohio, on June 17th. The meeting was called to order at 4 P.M. in the assembly hall of the Chamber of Commerce building by President James C. Wood. In his opening address the President welcomed the Institute and urged thoughtful consideration of the proposed revision of the by-laws. The committee on the President's address, to be given in the evening, was appointed, and consisted of Drs. J. W. Ward, of San Francisco, O. S. Runnels, of Indianapolis, and H. P. Bellows, of Boston.

The Executive Committee reported, through Secretary Gatchell, the selection of Cleveland as the place of meeting. The Publication Committee,

through its chairman, Dr. T. Y. Kinne, reported that the delay in the appearance of the Transactions was due to a strike in the printing office, and also to the neglect of participants to return the corrected discussions, and recommended that the by-law requiring that discussions be sent for revision by the participants be repealed, and that all papers be in charge of one person. The report was received and the recommendation as to the change in the by-law was referred to the committee in charge of that work.

The Treasurer reported a cash balance of \$339.02. The report was referred to an auditing committee consisting of Drs. J. B. G. Custis, W. H. Hanchett and J. P. Cobb.

The local committee, through Dr. J. Richey Horner, reported the various arrangements for the entertainment of the members.

Dr. W. H. Hanchett, for the Interstate Committee, reported on the growth of homœopathy and urged that the members of the school stand by its basic principles.

On motion of Dr. T. Franklin Smith, a telegram of condolence was sent to the widow of the late Dr. Selden H. Talcott.

A communication was read from Dr. Burford, of London, announcing the death of Dr. Richard Hughes and inviting the co-operation of American homœopaths in securing contributions to the Hughes Memorial Fund to be presented to the widow. This work was left in charge of Dr. J. H. McClelland, who in a few moments secured over \$750, with a promise of much more. Dr. B. W. James presented resolutions on the death of Dr. Hughes, which were adopted by a rising vote.

The Board of Censors presented the names of 59 applicants for membership. Before the close of the meeting the number was increased to 166. The Institute then adjourned till 8 P.M.

Evening Session.

The public session was held in the main auditorium of the Chamber of Commerce building at 8 P.M. The invocation was pronounced by the Very Reverend Chas. D. Williams, D.D., Dean of Trinity Cathedral, after which Cleveland's famous mayor, Tom L. Johnson, delivered an address of welcome. Dr. Gaius J. Jones, Chairman of the local committee, welcomed the Institute in behalf of the Cleveland physicians. After a piano solo by Miss Nellie Belle Jones, First Vice-President Dr. Edward Hooper responded for the Institute to the address of welcome.

The annual address was then given by Dr. James C. Wood. The address dealt with the relationship of the homœopathic to the dominant school, discussing the influence of homœopathy upon the medical thought and practice of to-day, the question as to whether the time has yet come for the homœopathic to be merged into the dominant school, the evidences for the laws of similars, the obstacles to the growth in numbers, prestige and popularity of the new school, and, finally, our proper attitude toward the dominant school of medicine. The address throughout was broad and liberal, emphasizing the continual growth and prosperity of the homœopathic school, but showing that, in spite of the growing cordiality of the two schools in many of the cities, in other sections, and particularly in the country, the bitterest antagonisms still persist.

The committee on the President's address heartily endorsed the opinions of Dr. Wood, urging that the school retain its own organization until the truths for which we contend are accepted, and recommending that the address be printed and distributed to the profession. The Institute decided to include the committee's report in the pamphlet thus prepared.

Second Day.

The morning session on June 18th was called to order by the President promptly at 9.30 o'clock, and Dr. T. Y. Kinne, of Paterson, N. J., presented the report of the Committee on By-laws. This was still under consideration at the close of the session. The sections on neurology (Wm. Harvey King, M.D., chairman), gynæcology (H. F. Biggar, M.D., chairman), and clinical medicine (Wm. H. Van den Burg, M.D., chairman), then held general meetings, at which a large number of papers were read and discussed. Sectional meetings of these departments were held from 4 to 6 P.M.

During the morning the visiting ladies were driven through the parks and boulevards, after which they were tendered a reception at the Roadside Club by the Ladies' Reception Committee.

In the evening a reception was tendered to the members of the Institute and their wives at the Colonial Club. The handsome club-rooms were decorated with palms, and a fine orchestra contributed to the evening's pleasure. The guests were received by an Entertainment Committee, consisting of Dr. and Mrs. J. C. Wood, Dr. and Mrs. G. J. Jones, Dr. and Mrs. H. H. Baxter, Dr. and Mrs. D. P. Beckwith, Dr. and Mrs. J. Richey Horner, Dr. and Mrs. E. H. Jewett, Dr. and Mrs. H. D. Bishop, Dr. and Mrs. A. F. Baldinger, Dr. and Mrs. Frank Kraft, and Dr. A. B. Schneider, together with a number of members of the Ladies' Entertainment Committee. A number of the ladies of the Board of Managers of the Huron Street Hospital assisted in the entertainment of the guests. Light refreshments were served in the red room adjoining the ball room.

Third Day.

The morning session on June 19th was devoted to the report on the revision of the constitution and by-laws. As adopted by the Institute, this report abolishes the sections and provides, instead, for five bureaus, viz.: (1) *Materia Medica and Therapeutics*; (2) *Clinical Medicine and Pathology*; (3) *Homœopathy*; (4) *Pædology*; (5) *Sanitary Science and Public Health*. The following societies are recognized as parts of the body: The Surgical and Gynæcological Society of the A. I. H.; The Ophthalmological, Otological and Laryngological Society of the A. I. H.; the Obstetrical Society of the A. I. H.; and the Electro-therapeutical Society of the A. I. H. Hereafter the Executive Committee will receive the invitations from and investigate the places of meeting and report to the Institute, the latter electing the meeting-place, as heretofore. The office of recording secretary is abolished, the general secretary fulfilling his functions. The number of committees has been reduced to the following: (a) Organization, Registration, Statistics; (b) International State Committee; (c) International Bureau of Homœopathy; (d) Intercollegiate, (e) Drug Provings, (f) Committee on Medical Examining Boards. Several minor changes were also made.

At 11 o'clock the section in Surgery, Chas. E. Kahlke, M.D., chairman, reported in general meeting, and this was followed by Pædology, J. P. Rand, chairman, and later Sanitary Science and Public Health, Chas. F. Adams, chairman. At 4 o'clock each of the above held sectional meetings.

During the morning Mrs. H. F. Biggar entertained the ladies at an informal breakfast at the Hollenden, followed by a long drive, which included the Rockefeller's beautiful grounds at "Forest Hill." Following this came a reception at the home of Mrs. James C. Wood, on Amesbury Avenue. Mrs. Wood was assisted in receiving by Mrs. H. H. Baxter and the ladies of the Entertainment Committee.

In the evening the General Alumni Conclave was held in the assembly room,

Dr. E. H. Jewett, of Cleveland, presiding. Dr. J. Richey Horner delivered the opening address. Dr. Wood read a letter from Thomas P. Wilson, M.D., of Detroit, an ex-President of the Institute, offering his greetings. Songs by the Ionic Quartette were interspersed with speeches by the representatives of the colleges, who were as follows:

Detroit, S. H. Knight, M.D.; Denver, D. A. Strickler, M.D.; Hering, H. C. Allen, M.D.; Southern, C. L. Rumsey, M.D.; Kansas City, M. T. Runnels, M.D.; Minnesota, E. L. Mann, M.D.; San Francisco, J. W. Ward, M.D.; Iowa, Geo. S. Coon, M.D., and Geo. Royal, M.D.; Chicago Homœopathic, E. H. Pratt, M.D.; Michigan, J. M. Lee, M.D.; Boston, J. P. Sutherland, M.D., and G. B. Rice, M.D.; Pulte, J. D. Buck, M.D., and Chas. Gatchell, M.D. New York, E. H. Linnell, M.D., and W. A. Dewey, M.D.; Hahnemann, of Chicago, J. P. Cobb, M.D.; St. Louis, W. B. Morgan, M.D., and J. A. Campbell, M.D.; Dunham, G. P. Waring, M.D.; Southwestern, Geo. S. Coon, M.D.; and Hahnemann, of Philadelphia, J. H. Carmichael, M.D. A collation given by the Faculty of the Cleveland College followed the exercises.

Fourth Day.

The Institute was called to order by President Wood. The committee on election of officers reported that as yet no election of president had resulted, and that another ballot was necessary. Thereupon another ballot was taken, with the following result:

President, Joseph P. Cobb, M.D., Chicago; *1st Vice-President*, H. F. Biggar, M.D., Cleveland, O.; *2d Vice-President*, H. Belle Brown, M.D., Cleveland, O.; *Secretary*, Ch. Gatchell, M.D., Chicago; *Recording Secretary*, J. Richey Horner, M.D., Cleveland, O.; *Necrologist*, C. A. Weirick, M.D., Chicago; *Censor*, Millie J. Chapman, M.D., Pittsburg.

A number of places of meeting were proposed, but finally Dr. J. Herbert Moore, of Brookline, Mass., secured the floor and invited the Institute, in behalf of the Boston Homœopathic Medical Society and the Boston Surgical and Gynæcological Society, to meet in Boston or its immediate vicinity. This was accepted by a unanimous vote.

Dr. J. B. Garrison offered a report in behalf of the Committee on Medical Examining Boards, in which reciprocity between the various State boards was urged. Dr. Dearborn reported, for the Intercollegiate Committee, that the various colleges should adopt a curriculum consisting of not less than four terms of six months each. They recommended that the National Medical University of Chicago be denied recognition. The report was adopted. Dr. J. B. McClelland reported that the work of the Hahnemann Monument Committee was nearly completed, and that a souvenir volume telling of the work and containing the speeches delivered at the dedication was in press. Dr. B. F. Bailey reported for the Committee on Resolutions, and Dr. W. A. Dewey for the Committee on Drug Proving.

A telegram of condolence was sent to the family of the late Dr. E. C. Price, of Baltimore, who died while the Institute was in session.

The sections in Obstetrics, J. P. Cobb, chairman, and in Materia Medica, C. F. Menninger, chairman, held interesting sessions during the day. The Ophthalmological, Otological and Laryngological Society, E. H. Linnell, M.D., presiding, held a general session during the afternoon. Each of the sections held separate meetings in addition.

The memorial services were held in the evening. Dr. Wood stated that a telegram had been sent to the widow of Dr. Alfred I. Sawyer, of Monroe, Michigan, a former member of the Institute. Dr. T. Y. Kinne, the chairman

of the committee, then assumed charge of the exercises. The invocation was pronounced by the Rev. Ward Beecher Pickard, D.D., of Epworth Memorial Church. Dr. A. C. Cowperthwaite, the necrologist, read the names of the members who have died during the past year, eleven of whom were seniors: Sarah W. Andrews, Chicago; Francis Boericke, Philadelphia; Chas. L. Bonnell, Brooklyn; Alonzo Boothby, Boston; John C. Burgher, Pittsburg; Wm. C. Couden, Denver; F. E. Downey, Clinton, Ill.; Jas. C. Duncan, De Kalb, Ill.; E. A. Fisher, Buffalo; Hayes C. French, San Francisco; John A. Gann, Wooster, O.; Julia Goodman, Hamilton, O.; Gustavus E. Gramm, Ardmore, Pa.; Anna E. Griffith, Camden, N. J.; John R. Haynes, Indianapolis; William Tod Helmuth, New York; Henry C. Houghton, New York; John C. Kirkpatrick, Los Angeles, Cal.; Chas. E. Pinkham, Sacramento, Cal.; Elias C. Price, Baltimore, Md.; Hudson J. Pulver, Torrington, Conn.; Francis R. Schmucker, Reading, Pa.; Jessie Shepard, Buffalo; Bowman H. Shivers, Haddonfield, N. J.; Sarah Smith, Council Bluffs, Ia.; Selden H. Talcott, Middletown, N. Y.; Alonzo L. Talmage, Waterloo, N. Y.; William Von Gottschalk, Central Falls, Conn.; Grove H. Wilson, Meriden, Conn.; and Richard Hughes, Brighton, England.

Eloquent addresses were made by John C. Sanders and H. H. Biggar, of Cleveland, and A. C. Cowperthwaite, of Chicago, while Miss Effie Stewart, of New York, rendered appropriate vocal solos.

Fifth Day.

The closing session of the Institute occurred on Saturday morning. The Interstate Committee offered a report through its chairman, Dr. W. H. Hanchett, recommending that all States have State Societies; that the State Boards endeavor to secure reciprocity from neighboring States, and that, as there is great need of homœopathic practitioners in various sections, the colleges be supplied with lists of desirable locations.

The President appointed the following chairmen:

Chairmen of Committees.

Organization, Registration and Statistics, T. Franklin Smith, M.D., New York; *International Bureau of Homœopathy*, George B. Peek, M.D., Providence, R. I.; *Drug Provings*, Howard P. Bellows, M.D., Boston; *Publication*, Geo. F. Shears, M.D., Chicago; *Medical Examining Boards*, H. H. Baxter, M.D., Cleveland; *Transportation*, C. E. Sawyer, M.D., Marion, O.; *Press*, DeWitt G. Wilcox, M.D., Buffalo; *Resolutions*, B. F. Bailey, M.D., Lincoln, Neb.; *Memorial Services*, E. B. Hooker, M.D., Hartford, Conn.

Chairmen of Bureaus.

Materia Medica, Geo. Royal, M.D., Des Moines, Iowa; *Clinical Medicine and Pathology*, Jno. W. Dowling, M.D., New York; *Pædology*, Anna Spencer, M.D., Batavia, Ill.; *Homœopathics*, T. Y. Kinne, M.D., Paterson, N. J.

The Censors reported that nearly 500 members and an equal number of visitors were in attendance. A vote of thanks was extended to the Local Committee, the citizens and the press of Cleveland; Dr. Wood, the President, was thanked and responded with a short speech; and Dr. J. P. Cobb, the President-elect, was called upon and replied with a few appropriate words. The Institute then adjourned.

The Senate of Seniors.—In all, sixty-two seniors were in attendance at the Institute meeting this year. They held four sessions, and admitted to membership, H. P. Bellows, Boston; Geo. W. Bowen, Ft. Wayne; J. D. Buck, Cin-

cinnati; J. A. Compton, Indianapolis; N. B. Delamater, Chicago; C. G. Higbee, St. Paul; W. H. Jenny, Kansas City; N. Emmons Paine, West Newton; W. G. Richardson, St. Louis; E. B. Spinney, Reed City; E. V. Van Norman, Los Angeles; and J. H. Wilson, Bellefontaine. Dr. N. Emmons Paine was ushered into this distinguished body by his father, Dr. H. M. Paine, who presided in the absence of Dr. Hiram L. Chase, of Cambridge. On Thursday evening the seniors were entertained at the Hollenden by Dr. H. F. Biggar. The loving cup was passed around and suitable speeches were made. The following are the officers: *President*, Horace M. Paine, Atlanta, Ga.; *Secretary*, T. Franklin Smith, New York; *Treasurer*, T. Y. Kinne, Paterson, N. J.

The Meissen.—The Society organized among the ladies accompanying Institute members to the meetings continued its work by bringing together the visitors and introducing them to the Local Committee, of which Mrs. H. H. Baxter was the chairman. Every moment of the week was filled, luncheons, receptions, drives, and theatre parties following each other in rapid succession, and every woman found her visit to Cleveland to be one round of pleasure. The officers for the ensuing year are: *President*, Mrs. E. B. Horku, of Hartford; *First Vice-President*, Mrs. Geo. W. Roberts, of New York; *Second Vice-President*, Mrs. J. Herbert Moore, of Brookline; *Secretary*, Miss Emily F. Paine, of New York; and *Treasurer*, Miss E. Louise Kinne, of Paterson.

The Ophthalmological, Otological and Laryngological Society.

—The Homœopathic Ophthalmological, Otological and Laryngological Society met in its Fifteenth Annual Session in the Colonial Hotel on June 16th, President C. Gurnee Fellows, M. D., of Chicago, presiding. A large number of papers were read and discussed, including one on Cataract, by E. J. Bissell, M. D., of Rochester; Syphilis of the Optic Nerve and Retina, by T. M. Stewart, M. D., of Cincinnati; Intraocular Tumors, with Lantern Slide Demonstrations, by J. H. Ball, M. D., of Bay City, Mich.; Syphilis of the Larynx, by G. B. Rice, M. D., of Boston; Acute Hoarseness of Singers and Public Speakers, by E. D. Brooks, M. D., of Ann Arbor; and Pharyngo-Keratosis, Benzozone, and the Treatment of Tonsillar Affections, by R. S. Copeland, M. D., of Ann Arbor. Adrenalin was discussed by G. H. Bagby, M. D., of Richmond, Va., and D. A. MacLachlan, M. D., of Detroit; while Glaucoma was discussed by Drs. C. Joseph Swan, of Chicago; William Blair, of Pittsburg; J. A. Campbell, of St. Louis, and E. H. Linnell, of Norwich, Conn. In the evening over 100 members of the society banqueted together and listened to the presidential address of Dr. Fellows. Dr. Bellows reported on the re-proving of the materia medica now being carried on by the society. The following officers were elected: *President*, Dr. George B. Rice, Boston; *First Vice-President*, Dr. Roy S. Copeland, Ann Arbor; *Second Vice-President*, Dr. William W. Blair, Pittsburg; *Secretary*, Dr. J. Ivimey Dowling, Albany; *Treasurer*, Dr. Geo. W. McDowell, New York; *Censors*, Drs. Irving Townsend, Fred D. Lewis, E. L. Mann, H. S. Weaver, and D. A. Strickler.

Surgical and Gynæcological Association of the A. I. H.—

The opening session of the Surgical and Gynæcological Association of the American Institute of Homœopathy was called to order by the President at 10 A. M., in the banquet hall of the Hotel Hollenden. The report of the Secretary was read and approved. The report of the Treasurer was read, and, on motion, referred to the Auditing Committee. Drs. Runnels and Pratt were appointed on this committee. The Executive Committee made no report. Under unfinished business the question of uniting with the American Institute of Homœopathy was taken up and discussed at great length, but no definite action was taken beyond an understanding that all members work within the Institute for the accomplishment of this purpose.

New business was called for, and under this the election of officers was held, resulting as follows: *President*, C. S. Runnels, M.D.; *First Vice-President*, W. E. Green, M.D.; *Second Vice-President*, G. C. Jeffery, M.D.; *Secretary*, J. W. Hassler, M.D.; *Treasurer*, W. A. Keegan, M.D.; *Censors*, E. S. Bailey, M.D., two years; E. H. Pratt, M.D., one year.

The first paper, entitled "A Case: Fracture of the Neck of the Femur," by Dr. T. D. Smith, of Jackson, Mich., was read and discussed. Dr. Runnels opened the discussion, and said he thought a great many cases of fracture at this point were given up too easily in old persons, and cited a case of a patient a hundred years old who had obtained sufficient union to walk upon the leg.

Dr. Pratt reported a case in which a transverse intracapsular fracture had been taken for a bruise, and the patient went on crutches for three years, and a good union was formed in this case. Dr. Jeffery asked how much of the two and a half inches shortening was remedied in Dr. Smith's case. Dr. Smith replied that at the time the patient left the hospital there was no shortening. Dr. Ogden spoke of the eversion of the foot as being one of the best diagnostic symptoms in these cases of intracapsular fracture. Dr. Green said it had been his experience that where the head of the bone had been removed, and ligamentous union obtained, patients would sometimes get up from bed with apparently little shortening, but after being on their feet for a while the shortening would increase until it reached an inch or more. He said he did not approve of plaster-of-Paris dressings in these cases except where the joint has been opened, and it is desired to put the limb in a fixed position. Dr. Hartman spoke of the large number of physicians who, just because a fracture is an old one, will put patients to bed with no treatment, simply because they fear they will get no union. He mentioned two cases which, by elevating the foot of the bed and placing the limb in a sliding cradle, had received perfect results. Dr. Coon said that in a case of impacted fracture eversion and shortening cannot be relied upon as symptoms, and that in cases of old people who are weak and feeble, some of them may not be able to stand the confinement. He spoke of several cases in which treatment had to be abandoned on account of keeping the patient on his back. Dr. Pratt reported a case where a lady in confinement had arisen from bed with apparently four inches of shortening. Examination showed the adductor longus muscle to be extremely taut, and on cutting this the limb immediately went back into its normal position. Dr. Smith, in closing, said that at the time his patient left the hospital he was not bearing any weight upon the foot, but it was his idea that when walking on it there would possibly be some shortening.

On motion by Dr. Hassler, the meeting re-opened under new business. Dr. Bailey moved that a committee of three be appointed to draft resolutions on the death of Dr. William Tod Helmuth. Motion seconded and carried. The President appointed on this committee Dr. Bailey, Dr. Pratt and Dr. Runnels. On motion, the meeting adjourned.

The second session was called to order by President Hartman at 2.30 P.M., Monday, June 16th. The first paper of this session was by Dr. E. H. Pratt, "The Passing of an Old Friend, the Tourniquet." Dr. McClelland opened the discussion. He reported a case where the amputation of a very large thigh was followed by a deep abscess at the point of application of the tourniquet. He said he had not witnessed the dire effects of shock so much, but had noticed the bruising of tissue, so that there was an unnecessary amount of effusive swelling.

Dr. Green asked if Dr. Pratt meant by the tourniquet the elastic bandage, and any compress of the limb to prevent hæmorrhage. Dr. Pratt replied that he did.

The meeting was then re-opened under new business. Dr. Bailey, chairman

of the Committee on Resolutions on the death of Dr. William Tod Helmuth, read a report, which was adopted. Dr. Wood placed in nomination as an honorary member the name of Dr. J. H. McClelland, who was unanimously elected by a rising vote. The resignation of Dr. A. E. Neumeister, of Kansas City, was presented, and on motion accepted. Dr. B. H. Ogden, St. Paul, Minn., and Dr. Warren H. Rand, Charlotte, Mich., having passed the Board of Censors, were elected members.

The next paper was by Dr. J. W. Hassler, of Philadelphia, "Some Observations on Anæsthesia." Dr. Runnels opened the discussion. He said he preferred chloroform as an anæsthetic, and used it almost exclusively in his practice, using it iced to prevent nausea and vomiting after the operation. He advocated allowing the patient to breathe deeply and regularly so as to drive out the residual air, and not having the lower portion of the lungs filled not only with chloroform but carbonic gas.

Dr. McClelland said it has been his custom not to feed the patient before an operation, but to give an enema of predigested food, liquid peptonoid, and a half normal saline solution, and repeat this enema before the patient leaves the operating room. He said he was a believer in the C. and O. preparation, and had used it exclusively in his practice ever since it was first announced by Dr. Northrop.

Dr. S. F. Wilcox reported having witnessed an operation on a child six or seven years of age, where ether had been given, and the operator explained his reason for so doing by stating that it had been found by investigation that the greatest proportion of deaths under chloroform had occurred in the first decade of life. Dr. Colstein said he had given anæsthetics for fifteen years, and believed in giving chloroform rapidly until in the second stage, then slowly. He said he never used oxygen for the reason that he has always chosen chloroform in preference to air. In the case of habitual drunkards, he said he differed with Dr. Hassler, and believed that ether was safer than chloroform. Dr. Green said that, like Dr. Runnels, he preferred chloroform as an anæsthetic, and used it in almost all of his cases. He said he did not allow undergraduates or inexperienced doctors to administer anæsthetics for him, but wanted a man more experienced in anæsthesia than he is in operating. He said that he did not believe in irritating the eye by sticking the finger into it, as it was unnecessary. Dr. Henchitt said it had been his experience that by careful use of oxygen patients will come out of the operation sweet and fresh, and not troubled with nausea. He said that chloroform is a good, safe anæsthetic, if carefully given, and by the use of oxygen afterwards, patients will be relieved of all troublesome nausea.

Dr. Green said that he allowed his anæsthetist ten dollars for every operation, and gave him to understand that if the result was good he would receive ten dollars extra. For minor operations he said he gave five dollars. Dr. Ogden said that, in reference to anæsthetics in obstetrics, he had never found that ether would do as well as chloroform, as it is too slow in its action. He said he had never seen any danger from the use of chloroform as it is ordinarily given. Dr. Newton said he had seen something of the value of nitrous oxide as an anæsthetic, particularly in clinics, as the patients do not have to be long anæsthetized. Dr. Carmichael said that he believed the danger from chloroform was in the first stage, that it should not be pushed at the very beginning, but after that it could be given more rapidly. He said he met with very few patients but what he could anæsthetize quickly, thoroughly and easily with ether by the Allis inhaler, where they can get plenty of air. He said that, where an experienced anæsthetist was not accessible, and where the patient could not be transported to a hospital, he felt that he could trust the majority

of medical men with ether. Dr. Hassler, in closing, said that when an operator is called away into the country to do an operation, he should always take his anæsthetist with him. In regard to Dr. Runnels' statement to have the patient do something, as counting, he said it was better to leave the case alone to quiet and rest, and let the operator do the talking, as it is the action of the suggestions on the patient's mind that has a quieting effect. Dr. Hassler said that in some five thousand cases he had anæsthetized, possibly thirty-five hundred had been with ether, and the average time was three and one-half minutes, by the low method. He said he believed in touching the eyeball, for by so doing you can tell the amount of reflex, and how much anæsthetic the patient has. In regard to carbonic acid gas, he said he liked a certain amount of it, and that he had observed that in a room containing ten or fifteen people patients will take less anæsthetic, and there will be less shock.

The next two papers were by Dr. S. F. Wilcox, "Unlimited Usefulness of Intravenous Salt Infusion," and by Dr. E. Z. Cole, "Surgical Shock—How Shall We Treat It?" and were discussed together. Dr. Pratt, in opening the discussion, said he had never heard anybody advocate salt solution as a hæmostatic, and never supposed it was good for that. He said that he was on the surgical staff of the Cook County Hospital, and had seen many cases of railroad accidents, gunshot wounds, etc., and in all, their greatest hope and greatest reliance was in salt solution. In regard to injecting the solution against the blood-current, he said that where he was going to use intravenous injection, he would certainly throw it the way the blood goes, and not try to dam the stream. Dr. Hassler said he had helped perform from a hundred and fifty to two hundred of these intravenous infusions in the last ten or twelve years, and the cases that were thus helped amounted to possibly 90 per cent., and that he had seen it stop hæmorrhage. He said that of late he had been adding to the salt solution from twenty to forty drops of adrenaline. He cited a case where a patient with an ectopic gestation had been infused with two quarts and a pint of solution, and an hour after the infusion was brought to Philadelphia, a distance of fourteen miles, and operated thirty-six hours after. The patient lived seventy-two hours, and then died of fatty heart. Dr. Bailey spoke in support of Dr. Cole's paper, and said that while the patient is still on the table the nurse, prepared for that purpose, should introduce into the rectum a quart of normal salt solution, thereby saving the possibility of shock, and he stated that it was his intention, before the patient leaves the table, to have the normal salt solution injected under the modified Trendelenberg position, as in that way the infusion goes higher into the intestine. Dr. Briggs said he had not had any shock to treat for a number of years, because he injected hot normal solution in all cases where the operation was not on the rectum. He said a great deal of the shock comes from improper care of the anæsthetic, and that a great many men will get frightened and begin to inject morphia and nitro-glycerin when unnecessary. Dr. Pratt said that he did not use intravenous infusion in all cases of shock; that there were cases where intravenous was better, and other cases where rectal was better. In regard to the temperature, he said that when a solution of 112° to 115° is put into a man's veins, the temperature will come up, and, unless some anodyne is given, chill and fever reaction is liable to follow. Dr. Roberts said that the treatment should be tempered to the case, and that all different methods have their value. He said the great value of the intravenous was in those cases where immediate reaction was needed. In regard to the general subject of stimulants, he said he thought the whole category had been a disappointment. He said the avoidance of shock is the great question, and that this can sometimes be accomplished by the use of large quantities of water, by doing all these operations in a very warm room, 85° to

90°, and by quick, but not hurried, work, giving plenty of time to details. Dr. Green said that in his abdominal infusions, when he would call upon a strange nurse for water, they would invariably give it to him very hot. He said he never injected a solution into the arm over 105°, and asked Dr. Roberts for his opinion on the subject. Dr. Roberts said that as the blood from the portal vein is 108°, he did not believe fluid put into the abdomen from 112° to 115° would do any harm. Dr. Wilcox said he did not change his opinion, that he believed that intravenous salt infusion had a very limited scope, and that in a few years very much less would be heard of it. As regards the time required, he said you do get action very rapidly with intravenous, but for reasons already mentioned, did not consider that all to be desired. Dr. Cole said the important point he wanted to emphasize in his paper was to anticipate shock and prevent it by these measures, and that if the patient is allowed to get well under shock any measures that may be adopted will be disappointing.

The next paper was by Dr. H. P. Cole, Hartford, Conn., "The Present Methods in Orthopaedic Surgery." Dr. Newton asked Dr. Cole how he would recognize that talipes has referred to congenital origin, and how he would treat the case at birth or how soon he would begin treatment. Dr. Sawyer testified against the plaster cast. He said it is an abomination in any case of joint-disease, simply because it does not do what it is intended to do, but locks up a joint that should have the observation of the surgeon. He said the first cardinal principle in the treatment of joint-disease is to overcome rigidity, as it is that which perpetuates inflammation, and any appliance that will do that is the thing to be used. Dr. Cole said that his paper was particularly on joint-disease and not on the treatment of talipes. He said before the child can walk it should be treated by manipulation, and after it can walk the shoe should be so adjusted that it will walk correctly. Dr. Newton said he quite agreed that you could change the position of a newly-born infant's foot into a normal position, or at any rate a position which will admit of putting the whole bottom of the foot on the floor and standing upon it, and in that way treatment could begin.

The meeting then adjourned until 8 P.M.

The third session was called to order by President Hartman at 8 P.M., in the banquet hall of the Hotel Hollenden.

Dr. Runnels, chairman of the auditing committee, reported that the accounts of the treasurer had been audited and found correct. Report was accepted and committee discharged. Dr. Runnels then took the chair, and appointed as the committee on the President's address, Dr. DeWitt G. Wilcox, Dr. J. Emmons Briggs and Dr. C. B. Kinyon.

The President's address on "Expert Testimony" was then read.

Following the President's address, Dr. C. E. Sawyer read his paper entitled "Signal Lights." Dr. Runnels opened the discussion. He said that the thought "once insane always insane" is not well founded, as shown by this paper and in the experience which has come to physicians in recent years; that when the mind has gone wrong it is like any other organ that has gone wrong; and that it is the duty of the doctor to find the causation and remove it. He said he was becoming profoundly impressed with the belief that a great many persons met with in insane hospitals ought never to have gone there. Dr. Smith said the question of blood analysis and urinary analysis and other so-called laboratory means of investigation and diagnosis is an important one to the homœopathic doctor. Dr. Jeffery said that he was disappointed to note that Dr. Sawyer advocated that surgery be not employed in these cases, that it had been his experience and observation that women were much better after the various operations to which the surgeons subject

them. He said it was not quite clear whether the case of insanity in question was due to the morphia or to the operation. Dr. Sawyer, in closing, said that he was not trying to discourage surgery, but simply referred to this case to present what he thought to be true and conservative in surgery. He said he wished to emphasize the fact that surgeons should study their cases more thoroughly and more scientifically, and only use those surgical measures that are absolutely indicated.

The next subject was "The X-Ray in Surgery," by Dr. G. M. Christine. Dr. Cole opened the discussion. He reported a case of lupus of the ear which had been cured by the X-ray, and also a case of glandular enlargement of the neck which in the course of four weeks had gradually subsided under the X-ray treatment. He asked the essayist what was the probability of treatment of birth-mark by the X-rays. Dr. Christine replied that he had no experience in that connection.

The next paper was by Dr. J. H. Carmichael, "Some Experience with Mamorek's Serum." Dr. Hassler, in opening the discussion, asked how Dr. Carmichael could tell that the recovery in cases of pus and pus evacuations was due to the injection of Mamorek's serum. He said that he could recite possibly seventy-five cases where 20 c.c. of antistreptococcus had been given with no result. He said he had had one good recovery with the fluid, but after that had no success whatever. Dr. Carmichael in closing said that in the pus cases he believed that the serum had everything to do with the recovery, that he did not confine himself entirely to antistreptococcus, but in a case of peritonitis would not hesitate to give a patient salt solution, nor to give creasote internally in a case of septic discharge.

The fourth session was called to order by the President at 10 A.M., Tuesday, July 17th, in the banquet hall of the Hotel Hollenden.

The paper by Dr. Horace Packard and Dr. J. E. Briggs, entitled "Inquiry into the Etiology and Pathology of Appendicitis, with a Report of a Series of Suppurative Cases," was read by Dr. Briggs. Dr. Kahlke opened the discussion. He agreed with the paper in the early diagnosis and radical treatment of appendicitis, and said that if physicians could impress patients with the great danger of appendicitis, that the case with the mildest symptoms is sometimes the most severe, they would be doing a great deed for humanity. Dr. McClelland said that he thought that many of the causes of these attacks of appendicitis are distinctly traumatic, not by direct blow or injury, but by some force brought to bear in the way of pressure. Dr. Ogden reported the case of a child less than two years old who had had repeated attacks of colic, seemingly indigestion. After some time it was decided that the attacks were the result of appendicitis, and operation proved this to be true. Dr. Wilcox said he was not quite in position to second Dr. Packard's suggestion of the removal of the appendix in every child, but considered that every physician should feel under obligation to Dr. Packard for the mere suggestion, in order that it might be investigated further. Dr. Pratt said he would rather take his chances of recovery by the waiting treatment than by any surgeon's knife in the world. He said he had seen cases die under the knife that would have had a better chance of recovery by waiting. He said the knife in these cases is called for only to evacuate pus. Dr. Roberts, Dr. Green, Dr. Runnels, Dr. Walton and Dr. Wilcox all spoke strongly in favor of early diagnosis and prompt surgical measures in the removal of the appendix. Dr. Briggs said in closing that, in regard to the evolution of the appendix, it was an organ that at one time was useful but was fast passing away.

The next paper was by Dr. O. S. Runnels, "Meckel's Diverticulum as a Surgical Factor." (See page 572.) Dr. Wood opened the discussion. He

said that it was true that Meckel's diverticulum is met with in 2 per cent. of operations, and it is therefore a subject that deserves most careful consideration. Dr. Tuttle reported a case where three different diagnoses had been made within three weeks, one of appendicitis, one of abscess of the liver and one of inflammation of the gall-bladder, which proved to have been an infection of Meckel's diverticulum.

Next was a paper entitled "A Resume of Seventy Cases of Ventral Suspension of the Uterus," by Dr. E. S. Bailey. Dr. Hartman asked Dr. Bailey if he ever used the pessary. Dr. Bailey replied that he never did. Dr. Sawyer said it was his belief that in this operation physicians are enabled not only to relieve the physical condition in the way of pain and disturbances in the pelvic region but to discover other discrepancies that might bring around a more serious condition later in life. Dr. Nobles said that at first he did fixation in these cases, but of late his work had been confined entirely to suspension, and that in two hundred of these operations done there had been no death. Dr. G. F. Martin said that he was surprised that the essayist should say that either one of these operations should be advocated as preferable to the other, and that in his practice he had come to select carefully between suspension and fixation according to the age and future condition of the patient. He said that fixation is best in patients in whom pregnancy is not apt to follow, and suspension in cases where that condition is likely to arise. Dr. Briggs agreed with Dr. Martin as to the advisability of selecting between ventral suspension and fixation. Dr. Bailey said there were thirty different well-defined operations for ventral suspension and fixation, and that he simply wanted to present as a practical matter a class of cases that seemed to make this operation desirable. Dr. Smith asked if there was any special objection to opening the abdomen and releasing the adhesions if the fixation was so severe that the patient could not go on. Dr. Briggs said in regard to opening the abdomen instead of performing abortion that in his case in the first place, he removed one ovary and tied a ligature around the other one. A year and a half later pregnancy ensued, and the question then came up whether to separate the adhesions or perform abortion, and after consultation it was thought better to perform the abortion.

The closing session of the Association was called to order at 2.30 P. M., by the President, in the banquet hall of the Hotel Hollenden.

The first paper was by Dr. W. B. Van Lennep, "A Few Suggestive Thoughts Concerning the Operative Treatment of Cirrhotic Ascites." Dr. Biggar opened the discussion. He said that in the past year he had had three or four cases where life had been prolonged with great comfort by this operation, and that he thought it was an operation in which it was worth while to give the patient the benefit of the doubt. Dr. Pratt said that Dr. Van Lennep had grasped a principle that was used everywhere else, that physicians would scrape an old scar to make it heal, would curette a uterus for endometritis, would pass a sound in male urethritis, and why might they not go farther and scrape for ovaritis. He said he regarded the paper as one of the most important ever presented before members of the American Institute. Dr. Van Lennep in closing said that he had nothing to add, that the object of the paper was simply to invite discussion along this line, and was glad to know that some of his colleagues were working and thinking along the same lines as he.

Dr. C. B. Kinyon read the next paper, entitled "Removal versus Fixation of Uterus in Prolapsus of Third Degree in Old Women." Dr. Runnels said that it was the trend of his belief that it is better in cases of very pronounced procidentia to eliminate the organ. He said that in ventral suspension the adhesions made to the peritoneal wall soon elongate into ligaments, and there is sufficient mobility of the uterus for all practical purposes. Dr. D. G. Wilcox

said the results he had obtained in hysterectomy had been very unsatisfactory, and he doubted if he would use the method again. He said by this method the very organ it was necessary to support was removed, and that the procidentia in all probability was not so unpleasant and painful as the procidentia of the vagina and rectum, and that by bringing up the uterus and fastening it to the abdominal wall, not only was the uterus held up, but the bladder and rectum. Dr. Green said he thoroughly endorsed Dr. Wilcox's remarks. He said that in his experience he had found that the trouble lies more with rectocele and prolapsus of the vagina than with the uterus. Dr. Roberts said that he also had had very poor results with hysterectomy for cases of procidentia, and that it was only after a number of failures with hysterectomy that he took up the method of ventral suspension. Dr. Bailey said that he agreed with the position taken by Dr. Wilcox, and that the method he preferred was not suspension but abdominal fixation. Dr. Sawyer said that in his own experience he had become convinced that there is no support so good as Nature has made for the pelvic cavity, and that in every case he saves the uterus if that is possible. Dr. Kinyon said that in all cases where he performs hysterectomy, he at the same time does the repair work that is necessary in the vagina, because if the vagina is left as redundant as before, no good can be accomplished.

The meeting then reopened under unfinished business. The committee on the President's address made a report, which was accepted. The committee to adopt resolutions on the death of Dr. Boothby then rendered a report, which was received and filed. Dr. E. C. Van Norman, Los Angeles, Cal., having passed the Board of Censors, was elected a member. Dr. Hartman then thanked all the members of the society, as well as those who had written papers, and those who had taken part in the discussions, for their support in his administration through the past years. Following this the meeting adjourned.

Otological, Ophthalmological and Laryngological Society.—Report of the Committee on the Test-Proving.

Mr. President and Fellow-Members: The following report is made on behalf of the committee having in charge the test-proving which is being made under the auspices of this Society.

It will be remembered that immediately after the first report of this committee was submitted, at our last meeting, a donation of \$50 was made by Dr. A. B. Norton, as editor of the *Homœopathic Eye, Ear and Throat Journal*, towards meeting the general expenses of this proving. Two days after our society adjourned, our parent society—the American Institute of Homœopathy—took up the matter of our proving, and extended to us not only its hearty endorsement, but also aid of the most practical and substantial sort, in accordance with the following unanimous vote: "That a committee of three be appointed by the Chair to co-operate with the American Otological, Ophthalmological and Laryngological Society in carrying out the test-proving which that Society has undertaken; and that the sum of \$300 be appropriated from our treasury and placed at the disposal of the general director of that proving, to be used in defraying the expenses incurred."

With funds thus provided, the more practical work of preparation was begun. Arrangements were made for an ample supply of the tincture of the drug which was to be proved. This was duly prepared, in strict accordance with the directions contained in the Pharmacopœia of the American Institute of Homœopathy. It was received under seal from the maker, and was submitted for assay to Prof. Wilbur L. Saville, of the Massachusetts College of Pharmacy. His report places the question of its purity beyond doubt, and establishes the exact strength of the preparation which we are using.

In order to secure uniformity in the results of the proving in various cities, and also to secure such classification of results that they may be readily and accurately collated when received, the next task was to prepare a concise set of directions for the use of the special examiners upon the various Boards. Such a complete set is on exhibition in the hands of Dr. Swan, and may be examined by you at any time during our meeting. It consists of fourteen distinct parts or fascicles—one for each examiner. For each prover a separate set of forms is provided, and this admits of a satisfactory grouping and permanent classification and preservation in future, so that at any time these records will be available for the study or verification of the symptoms obtained. It was only after many weeks of earnest work and many consultations on the part of our colleagues that the material for these forms was provided. After this, it was no small labor to cast each part in definite arrangement for printing. Each set of forms contains 108 printed pages, in addition to the blank sheets interleaved. To save expense, this printing was entirely done by the mimeograph process, in a room adjoining your director's office, and under his personal supervision at all times. The best idea of this part of the work will be conveyed by the statement that 18,000 sheets of paper were used in the preparation of these sets of examiners' forms. Upon their completion a full sample set was forwarded to each of the local directors of the proving in New York, Brooklyn, Chicago, Philadelphia, St. Louis, Boston, Baltimore, Cincinnati, Buffalo, Cleveland, Detroit and Washington; also one to Dr. W. A. Dewey, of Ann Arbor, the Chairman of the Co-operating Committee of the American Institute; another to Dr. Geo. Royal, of Des Moines, the second member of the Institute Committee—the third member being Dr. J. B. Gregg Custis, our local Director in Washington. Dr. Royal subsequently organized a Proving Board at Iowa City, and himself became its Director, and has done most efficient service. Finally, a set of forms was forwarded to the Professor of Materia Medica at San Francisco, and one to Dr. H. W. Hoyt, of Rochester, who is actively engaged in the formation of a Proving Board among the staff-officers of the hospital in that city. In all, sixteen sample sets of the examiners' forms were thus distributed.

In response, requisitions for sets for actual proving were received from New York, Brooklyn, Philadelphia, St. Louis, Boston, Cleveland and Iowa City—in all, seventy full sets being thus supplied to seven Boards. The latest returns from the Directors of these Boards show twenty-five provings actually carried through and completed in accordance with the plan; five incomplete provings which were abandoned at various stages, but which will yield a few symptoms, and seven provings still in progress at the present time. The balance of the seventy sets requisitioned represents disappointments, and the cause of disappointment is the dependence of some Directors upon the promises of unpaid volunteer students. When it was found by these students that so much time was required for the special examinations, they simply withdrew.

This result was hastened by the attitude of some of the examiners themselves, who required the students to present themselves for their tests in office hours and await their turn. Instances were reported to me where students were kept waiting in this way for two hours or more. This is surely an injustice to the prover, and also to the other special examiners, whose arrangements are thus completely overthrown. The whole matter of disappointment from student provers comes back to the plain assertion, made in the original statement of our plan of proving, that students are *not available* as provers while they are in attendance upon their lectures and college work. The disappointments thus far experienced amount simply to so many demonstrations of facts which were plainly stated at the outset and are in no sense surprises. Another

fact which has been demonstrated is that, unless provers are receiving payment, their sense of responsibility is very light and their agreements are very easily set aside. To the average person, even a small payment carries with it the sense of a contract, and makes his engagements seem more binding. The importance of the examiners seeing the provers by appointment, instead of keeping them waiting during office hours, is also practically demonstrated. The whole proving lasts but three weeks; the routine examinations occur but once, twice or three times a week, and require, on an average, but three or four minutes each. A little effort on the part of the examiner to reach his office, on certain days, a half-hour in advance of his usual office hours, or to set aside a half-hour for this purpose in the course of the day outside of office hours, is all that is required, and this surely is not too much to ask of the busiest man in such a cause. When this course has been followed, when the provers have been paid, and when they are not students in active attendance upon college courses, the work has, in all reported instances, gone smoothly, and the results have been all that were anticipated.

And now as to these results. I cannot do better than to submit the report of our local director in Boston, Dr. E. P. Colby: "June 10, 1902. The first series of provings in this district having been completed, I think the following brief summary may be of interest. Five provers were employed, including both sexes, and the plan laid out in the prospectus was followed as rigidly as possible. For manifest reasons I will say nothing of the dosage. There resulted 125 well-established symptoms, of which 65 were subjective and 60 objective. Of the objective symptoms, at least one-half would not have been detected had it not been for the routine examinations of the specialist examiners, as they produced no subjective symptoms leading to their recognition by the prover. Divided among the examiners, the list of symptoms is as follows:

	Objective.	Subjective.	Total.
Director (general),	3	37	40
Eyes,	6	2	8
Ears,	14	13	27
Nose and Throat,	6	7	13
Skin,	0	2	2
Genito-urin. Female,	1	1	2
Urine,	11	0	11
Nervous System,	4	3	7
Physiological Tests,	12	0	12
Blood Examinations,	3	0	3

The manner in which several of the symptoms were duplicated (or more than duplicated) leads one to look upon the record as one of great value."

The idea is held by some of our colleagues who are working with us upon this proving (and is doubtless held by many more who as yet have not actively joined the work), that the examination of the provers by one competent man who directs the proving is sufficient, and would save much time, trouble and expense to all concerned—the provers being referred by the director to the special examiners for the verification and further testing of special symptoms when they actually arise. To those holding these views the following statement is made, in addition to the comment of Dr. Colby. In the course of the routine examination of the ears in the Boston provings just reported, there were noted, on two successive dates, eighteen symptoms of great practical value, a good proportion of these being objective symptoms of the plainest possible description. Here was an opportunity for a practical test, and with this end in view, the records made by the director upon the two dates referred

to were carefully examined to ascertain how many of these symptoms had been noted by him. They were found to be absolutely blank as regards the ears upon both dates. No statement whatever of their condition had been made to him, and his questions had elicited none; and a more careful questioner is not engaged anywhere in this work. In other words, but for the plan of routine examinations by the special examiner, which is characterized as unnecessary, every one of these valuable symptoms would have been lost.

There is one direction in which the plan upon which we are working can be still further strengthened and its scientific character developed; that is, to institute a series of experiments to determine whether the drug whose action we are testing is capable of producing changes in animal organs and tissues, and, if so, to ascertain and record the exact extent and nature of these changes. It is a pleasure to announce that definite arrangements for a series of experiments of this nature have been concluded, and that if characteristic tissue changes are demonstrated they will be recorded and their publication made possible by means of microphotography. The colleague who has so kindly consented to carry out this important work is Dr. S. C. Fuller, the pathologist of the Westborough Insane Hospital, in Massachusetts, and the experiments will be conducted in the laboratory of that institution.

And now, a word as to the future: The test-proving is going right on. Some of our Boards which have as yet done no work are raising money, which in some places has been given generously by State and local societies and by individuals, and are perfecting their organization and getting ready to begin provings in the fall. They will profit by the experiences of the Boards which have already begun the work. The older Boards, our pioneers, by virtue of these same experiences, are in a position to give us more provings of much greater value than the first undertaken. The result is going to be a success which will many times repay all the labor and vexation and self-sacrifice of the friends of this movement, who have given it such earnest and such able support.

It only remains, Mr. President, to ask more time for this Committee in which to complete its work, and to suggest that since all the results may be in hand before we meet again it may be wise, at this time, to make some provision for their publication.

Respectfully submitted,

Howard P. Bellows, M.D.,

General Director.

June 16, 1902.

After this report was received the following motion was made by Dr. W. R. King, of Washington, and carried by unanimous vote of the Society.

Moved, That the General Director of our test-proving be authorized to publish the results of this proving as soon as they are complete—the publication to be issued in the name of this Society. Also that he be authorized to send a presentation copy of this publication to the editor of every homœopathic journal in this country and abroad, and to advertise it in any manner which is customary. Also that the price of this publication be fixed, as nearly as may be, with reference to covering the actual expense incurred. Also that any deficit that may remain on account of this publication shall be made good by this Society to the amount of \$100, and that any profits which may accrue therefrom shall be appropriated by this Society to the advancement of drug proving.

Personals.—Dr. George Bickley has sailed for London and Paris, where he expects to spend the remainder of the summer.

Dr. W. F. Baker is in Europe, "taking in" the clinics.

Dr. H. L. Northrop is spending the summer in Ocean City, N. J.

Dr. E. R. Snader is in Europe; he expects to return about the first of September.

Dr. G. A. Van Lennep is in Germany doing post-graduate study.

Dr. W. C. Goodno is resting along the New England Coast.

Dr. Harry Weaver is taking work in the clinics of Europe.

Dr. A. Spooner has just returned from a year's study in Vienna.

Dr. Clarence Bartlett is spending most of the summer in town, busily engaged on the first volume of his "Clinical Medicine," which will be out by the first of October. The doctor goes to Atlantic City every night, and returns in the morning.

Dr. William B. Van Lennep is spending his evenings at Atlantic City.

Deaths.—Dr. J. Keasbey Weatherby, who was the successor of the late Dr. Bowman H. Shivers, of Haddonfield, N. J., died July 1st from exhaustion, following an operation for appendicitis several weeks ago. The deceased was born at Pedricktown twenty-eight years ago, and graduated from the public school at Pennsgrove, and afterwards prepared for college at the Pennington Seminary, and graduated as a physician from the Hahnemann College, in Philadelphia, in 1900. He was then appointed resident physician of the Metropolitan Hospital of New York City, and later succeeded Dr. Stewart as chief of staff of that institution. During the illness of the late Dr. Shivers he took charge of his practice, and after his death remained in Haddonfield.

Private Hospital.—Mr. A. Kincaid desires to announce that he has removed his private hospital from 131 North Nineteenth Street to 1818 Arch Street. This property was reconstructed for the purposes of a private hospital, and has been occupied as such for several years. It contains a modern operating room and all conveniences for hospital work.

The American Association of Orificial Surgeons.—The fifteenth annual meeting of the American Association of Orificial Surgeons will be held in Chicago, September 10 and 11, 1902. A program is being made up of lectures and papers by the leading specialists and practitioners in rectal, genito-urinary and gynecological work, and in the treatment of all chronic diseases. The orificial surgeons are the workers in the great field of the reflexes, and the profession generally is every day being brought closer to a realization of the fact that the reflexes play a most important part in the chronic manifestations of disease. Papers and discussions will cover the entire scope of the work, preparatory, operative and therapeutic, and the sessions will be of great benefit to all who attend. H. C. Aldrich, M.D., of Minneapolis, Minn., President; Ralph St. J. Perry, M.D., Secretary, Farmingham, Minn.

Dr. E. M. Gramm, of 1833 Chestnut street, announces that he is now equipped for the therapeutic administration of the X-ray (in the various forms of cancer, lupus, lupus erythematosus, etc.); also the static electric treatment of rheumatism, neuralgia, neurasthenia and all other affections requiring treatment by frictional electricity; also the cataphoric treatment of those diseases in which static cataphoresis is indicated. Office hours, from 9 to 11 A.M.; Sunday, 10 A.M. to 12 noon.

New York Letter.—Dr. John E. Wilson will be absent from the city from August 1st to September 15th.

Dr. C. C. Howard sailed for Europe July 26th.

Dr. Irving P. Sherman has left town for the summer.

Dr. H. Everett Russell is at Squirrel Inn, Haines Falls, N. Y.

Dr. Bukk G. Carleton will be in his office on Mondays only till September 3d.

Dr. Emanuel Baruch is in Europe.

Dr. Edward G. Tuttle will be out of town until September 15th. Dr. Ralph A. Stewart attends to Dr. Tuttle's summer practice here.

Dr. A. B. Norton will return from Europe September 29th. Dr. Munson will be in Dr. Norton's office during the summer, as usual.

Dr. J. T. Simonson will omit evening and Sunday hours in August and September.

Dr. Irving Townsend will be away until September 15th. Dr. Jones will care for patients in Dr. Townsend's absence.

Dr. Charles Deady will be in his office daily, except Saturdays and Sundays, to September 10th. Hours, 11 to 1.

Dr. Wm. Tod Helmuth, Jr., will join his family at Easthampton, L. I.

Dr. George Fred. Laidlaw is receiving congratulations on the advent of a son.

Dr. George W. McDowell is away for the summer months.

Dr. E. P. Swift is at Lake Mohonk.

Dr. Wm. H. Van den Burg sailed for Europe in July.

Brooklyn Homœopathic Hospital Alumni.—Will the doctors who have served a term of service in the Brooklyn Homœopathic Hospital kindly send their name and address to Dr. O. S. Ritch, 337a, Macon Street, Brooklyn, N. Y., Secretary of the Cumberland Street Hospital?

Announcement.—The Sixteenth Yearly Post-Graduate Course in Official Surgery by E. H. Pratt, M.D., will be held in the amphitheatre of the Chicago Homœopathic Medical College, corner Wood and York Streets, Chicago, Ill., during the week beginning with September 8, 1902, having a four hours' daily session.

Doctors invited to bring obstinate cases of every variety of chronic disease.

For particulars address

E. H. PRATT, M.D.,

100 State Street, Suite 1203,
Chicago, Ill.

State Board of Medical Examiners of New Jersey.—The annual meeting of the State Board of Medical Examiners of New Jersey was held at Newark, N. J., July 5th, and licenses were granted to the candidates who successfully passed the State medical examination at Trenton on June 17-18.

Forty-eight candidates were examined, representing the following colleges: Jefferson Medical College, 9; Baltimore Medical College, 6; Baltimore University School of Medicine, 4; College of Physicians and Surgeons, Baltimore, 4; The University and Bellevue Hospital Medical College, 4; Medico-Chirurgical College, Philadelphia, 3; Columbia University, Medical Department, 2; Maryland Medical College, 2; University of Pennsylvania, Medical Department, 2; University of the South, 2; Cornell University Medical College, 1; Hahnemann Medical College and Hospital, Philadelphia, 1; Harvard University Medical School, 1; Howard University, Medical Department, 1; Johns Hopkins Medical School, 1; Medical College of Virginia, 1; Shaw University, Leonard Medical School, 1; University of Naples, Italy, 1; Woman's Medical College of Pennsylvania, 1; Yale University, Department of Medicine, 1.

Of the total number of candidates examined, 40 were licensed, 1 was expelled, and 7 failed to pass, making a rejection of 16.6 per cent. Twelve midwives were examined for a State license, 5 of whom were licensed and 7 rejected, making a rejection of 58 per cent.

Examinations were held in materia medica and therapeutics, obstetrics and gynecology, practice of medicine, surgery, anatomy, physiology, chemistry,

histology, pathology and bacteriology, hygiene and medical jurisprudence. Two hours were given to each section, in which ten questions were submitted. A total average of at least 75 per cent., or 675 points out of a possible 900, was required to obtain a State license.

Of the candidates examined, 4 possessed the degree of A.B., 2 of Ph.G., 1 of P.D. and 1 of D.D.S.

The policy of the Board in establishing and maintaining reciprocal relations with other States whose examining and licensing requirements are at least equal to those of New Jersey has met with the approval of the profession. The number of States which have entered into reciprocity of medical license with New Jersey is steadily increasing.

The following officers were elected: *President*, Dr. John J. Baumann, Jersey City; *Secretary*, Dr. E. L. B. Godfrey, Camden; *Treasurer*, Dr. A. Uebelacker, Norristown.

The next examination will be held in September.

Obituary.—Dr. Martin Deschere died at his home, 334 West 58th street, New York, on Monday evening, July 21, 1902, aged fifty-four. The funeral was held at 10 o'clock, A.M., July 24, from his late residence; members of the Homœopathic Medical Society of the County of New York, attending in a body.

Dr. Deschere was well and widely known as a remarkably skillful physician, and as a medical scholar. His study was indefatigable, he wrote and thought with convincing clearness. He had practiced medicine over a quarter of a century. His specialty was children's diseases, of which subject he was professor in the New York Homœopathic Medical College and Hospital. Dr. Deschere was distinguished in another department of medicine, that of therapeutics. He adorned the prescriber's art. His knowledge of and his success in homœopathic prescribing was most noteworthy. He was rarely gifted in this field.

Dr. Deschere will be sadly missed, not only in the many professional circles with which he was identified, but amongst an extensive acquaintance, both social and fraternal. Dr. Deschere leaves a widow and three children.

John Hutchinson, M.D.

New York, A Cosmopolitan City.—On our way home from the Institute meeting at Newport, Dr. Van Baun and I arrived in New York by way of Sound steamer at about 7 o'clock Sunday morning. We were anxious to look over the New York College, and made that our objective point on landing. Taking the elevated uptown, we made the mistake of getting off at one station too soon. We proceeded to Avenue A, and made inquiry. The first man we met could not understand our questions. He was a Russian. We tried again, but this man likewise could not understand English; he was a German. The next man was a Frenchman, and his education in English was as limited as was ours in French. A Pole failed likewise to enlighten us, for we were not Polish. Nothing daunted, we did not hesitate to approach a party wearing a red fezzan; but he was unable to assist us, for he spoke only the language of the Sultan and Mohammed. Hungarian, Armenian, Spaniard and Italian were accosted in turn. Desperate we were, truly. Here we were in the greatest American City, but not a man we met could speak our native tongue. We walked on. With joyful feelings we spied a policeman. "At last," I cried, "we can find our way." Approaching the policeman, I said: "Can you direct us to the New York Homœopathic Hospital?" With rich Hibernian accents came the reply, "Is it the Home o' Pathrick Hospital ye's wants? Bejabbers, it's beyant."

THE HAHNEMANNIAN MONTHLY.

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A FEW SUGGESTIVE THOUGHTS CONCERNING THE SURGICAL TREATMENT OF CIRRHOTIC ASCITES.

BY WILLIAM B. VAN LENNEP, A.M., M.D., PHILADELPHIA.

(Read before the Surgical and Gynæcological Asso. of the Am. Inst. of Hom., June 17, 1902.)

I MUST ask your indulgence and preface my brief remarks by a word of explanation for recording the history of a single case—one belonging to a class which, while not common, comprises from fifty to seventy-five published operations. My object is not to give a statistical report of my experience with the procedure, which is too recent and too limited, but to invite a discussion along lines on which I have no doubt most of the surgeons present have been thinking, studying and working.

R. A. H., 56 years of age, married, a mason by trade, from North Carolina, applied at the Hahnemann Hospital for the relief of an umbilical hernia. He gave a history of malarial fever four years, and grippe eighteen months previously, together with typhoid and "bilious" fever more remotely. He denied syphilis, apparently truthfully, but acknowledged a prolonged and excessive alcoholic habit, which was well borne out by his anæsthetic conduct, at least.

He presented a thin-walled umbilical hernia about the size of a child's fist, spontaneously reducible in the supine and protruding in the erect position, but containing fluid, instead of gut or omentum. He dated the appearance of the hernia from the attack of grippe, since which time he had developed an

enormous ascites, associated with some anasarca of the legs and feet.

The report of the official hospital anæsthetist, Dr. J. W. Hassler, states that there were present both aortic systolic and slight mitral regurgitant murmurs, together with a heart enlargement of moderate degree. The respiratory efforts were labored, and but three ounces of ether were administered during the operation for this reason, and because it was quickly carried out (about fifteen minutes). The report also states that the urine was freely albuminous and contained casts, both hyaline and granular. The quantity is not given, but the urea is said to be below normal.

He was operated in my clinic on February 12th last, when, besides the radical cure of the hernia, the following conditions were noted, and Morison's operation was carried out, as follows:

I. Conditions:

(1) A typical "hob-nailed" liver, somewhat decreased in size.

(2) No perihepatitis; *i.e.*, capsule not especially thickened, and no adhesions.

(3) No peritonitis, diffuse, localized or tubercular.

(4) An enlarged spleen.

(5) Moderate jaundice, in the skin and especially in the conjunctivæ.

II. Operation:

(1) About three-fourths of the fluid was mopped out.

(2) The upper surface of the liver and the under surface of the diaphragm were energetically rubbed with sterile gauze mops until free oozing of blood was produced.

(3) The outer surface of the spleen and the adjacent parietal peritoneum were similarly treated.

(4) The retracted, short, thick omentum and the anterior parietal peritoneum were rubbed in like manner and united with catgut.

(5) The abdominal wound was then closed, together with the hernial opening, and a suprapubic "stab" was made, through which a gauze drain was introduced to the bottom of the pelvis.

(6) The usual dressings above, and an abundance of absorbent gauze (frequently renewed) over the drainage wound, were then

applied, and the head of the bed was well elevated to favor the escape of the ascitic fluid.

The after-course of the case was uneventful. Fluid drained freely through the gauze for a week, when the suprapubic wound was closed. On account of our crowded wards he was referred to the dispensary, March 4th, with both wounds practically healed, but with considerable ascites persisting. Dr. W. N. Hammond, out-patient surgeon, kept him under observation in the dispensary for about three weeks, when he went South, with his wounds firmly healed and the abdomen completely emptied of fluid. A letter from him at the end of May states that he is in perfect health, and only notes slight œdema of the ankles at night, and puffiness of the face and lids in the morning.

I intend shortly to follow with him Edebohls' suggestion and hyperæmize his kidneys by stripping, a procedure which, if we can judge by primary results, has met with admirable success in our hands, especially when we consider the hopeless outlook for these subjects of chronic Bright's disease.

Without burdening you with anatomical details which must be familiar to every surgeon, nor with a *résumé* of the literature or a list of operated cases, which are readily accessible, the procedure suggests two important principles which promise a broad field for "internal surgery" in what has hitherto been assigned to "internal medicine," namely, *draining anastomosis* and *hyperæmization of sclerotic organs*.

Post-mortem examinations have demonstrated abundant if not enormous anastomoses between the portal and systemic circulations after these operations; as, for instance, Rutherford Morison's case, in which a remote autopsy showed "extensive adhesions between the spleen, intestines, omentum and parietes, the bands containing little excepting blood-vessels, some as large as the radial artery, and even four inches in length." Again, such adhesions have been brought about more or less accidentally or incidentally, *i.e.*, what might be termed "Nature's cure." For example, Herrick's case, in which the ascites disappeared after an operation for strangulated hernia in a man whose abdomen had filled up after repeated tapplings; or Mitchell's and Bloodgood's case, in which adhesions, apparently established by Nature, were found between the omentum, transverse colon and the anterior abdominal wall, which contained large blood-vessels.

It should be borne in mind that such anastomoses must take place through a capillary system, as a too free communication has been found by experiments upon lower animals, when a direct opening was made between the portal and caval veins, to result in an acute, rapidly fatal toxæmia. Such symptoms, developing, as they occasionally do, after operation, should be controlled, as in non-operative cases, by diminishing the portal blood-pressure by light and appropriate diet and free purgation.

It may be of interest to note that such anastomoses will at least drain enough fluid from the peritoneal cavity to give relief in otherwise hopeless cases. This I have observed in a subject of rectal carcinoma with enormous hepatic metastases and ascites, in whom I attached the omentum to the anterior abdominal wall while carrying out an inguinal colostomy for an oncoming bowel obstruction.

Again, we note in the case above detailed that not only did the ascites disappear, but the moderate jaundice, or perhaps "the subicteroid hue of the so-called *facies hepatica*," followed suit, and digestion and general nutrition became normal. When we recall that enormous vascular adhesions have been found not only, as already stated, between the spleen, omentum and intestine, on the one hand, and the parietal peritonæum on the other, but also between the upper surface of the liver and the under surface of the diaphragm, we must conclude that such an improvement is doubtless due to the increased hepatic blood-supply. The same, we have reason to hope, will prove true in the case of the kidney, for we have met with vessels large enough to require ligation on dividing the adhesions of an anchored kidney which had stretched its moorings; and we have also observed in a number of cases as a primary result, namely, within a few days, the disappearance of casts and albumin, and an increase in the urea as well as the daily excretion of urine, following a double renal decortication.

Before leaving this hopeful prospective field, let me add a word of caution to my surgical colleagues. Cirrhotic ascites, pure and simple, is a terminal condition—one that means a few weeks, possibly two or three months, of life after the first palliative tapping; besides, it is usually associated with heart and arterial lesions, which greatly enhance the dangers of anæsthetic

and post-operative shock, to say nothing of the almost constant, incurable kidney mischief. Any operation, then, must necessarily be dangerous, and the mortality of this one is probably low when placed at from 30 to 40 per cent. The same will doubtless prove true in those practiced to increase the blood-supply of the kidney, unless early intervention can prove to the practitioner the permanence of its results. The surgeon should, therefore, work hand in hand with the medical expert, and should exercise the greatest care, lest by over-enthusiasm and indiscriminate operations he brings discredit upon his art and science.

THE DEVELOPMENT OF THE CLINICAL LABORATORY.

BY BARTUS TREW, M.D., BALTIMORE, M.D.

(Presidential Address to the Maryland State Homœopathic Medical Society.)

Fellow-Members of the Maryland State Homœopathic Medical Society :

Your constitution not only provides for an annual address by your president, but goes further, and states that in this address he shall make suggestions which in his mind may prove beneficial to the welfare of the society. I feel that my predecessors have well filled their obligations in this respect, and left little or nothing to be said at this time which would be aught than a repetition of their recommendations; therefore, I shall address you upon another subject, the consideration of which I hope may be of value to us.

The main fact that impresses one who views with deliberation the science of medicine as it stands to-day is that it probably owes more to the man of pure science than to the so-called practical man. I do not wish to be considered for one moment as suggesting that the practical man is not indispensable, for I realize that we could not do without him; but his success is essentially dependent, in many respects, upon the man of science. The practical man may trephine a cranium, but he must call to his aid the scientist to locate the abscess; he may perform many and difficult operations, but the laboratory worker has shown the cause of suppuration following

operation, and how it can be avoided. If, year by year, more of the causes of disease are recognized, it is because of the labor and investigations in the laboratory. Only a few years ago the laboratory had no place in the science of medicine; but it is not so to-day, for now it is recognized as occupying one of the most important positions.

Bearing in mind what Richet has said, that by experiment and science medicine is compelled to march forward, and being firm in my belief that the laboratory will be the means by which medicine will be advanced, I have selected for my subject this evening "*The Development of the Clinical Laboratory*;" and in doing so I have not lost sight of the fact that it bears a peculiar relationship to the principles of homœopathy. It may be said by some that the clinical laboratory can occupy no place in the practice of homœopathy, because the latter deals with the symptomatology of disease and the application of drug symptoms thereto. Nevertheless, the laboratory has come among us to stay. I say "among us" advisedly, for it has been introduced into our medical colleges and hospitals. In fact, the re-proving of our *Materia Medica*, as undertaken by the American Institute of Homœopathy, and for which this society has made an appropriation, shows that the importance of the laboratory is thoroughly recognized, for the investigations are to be entirely along the line of clinical laboratory methods. There can be no excuse, at this time, for any one not being more or less familiar with laboratory technique. In the time of Hahnemann and the pioneers of our school the science of medicine was very crude, the instruments used were expensive, and could only be used by experts; but such is not the case to-day. Many of the appliances are inexpensive, and only a little practice is necessary for one to become fairly adept in their use.

The question may be asked, "What do you mean by the term 'clinical laboratory'?" A clinical laboratory is one in which chemical, physical and biological methods of diagnosis are practically applied to the study of disease. Its existence is largely dependent upon and closely connected with the laboratories of chemistry, physics, biology and pathology. Of itself, it may be a research laboratory in the pure sciences as well; but it is essentially a laboratory of applied sciences in relation

to medicine, excepting such work as may have to do directly with the treatment and cure of disease. The clinical laboratory is one which pertains primarily to the diagnosis of disease; and, as I have said before, its relationship to homœopathy, which has nothing to do with diagnosis, but with the science of therapeutics, may be considered unique. I cannot do better here than quote from Dr. Norton's address as president of the American Institute of Homœopathy in 1901, in which he says: "Homœopathy must now make its powers especially felt in the domain of preventive medicine. In the past, our chief aim has been the cure of disease. Now, having placed the treatment of disease on a plane higher than ever before, we should turn our attention to the new lights thrown upon the causes and nature of disease to its complete prevention."

However, it is not my intention to discuss the relationship existing between this phase in the advance of medical science and the principles and practice of homœopathy. The sooner we recognize the fact that a correct diagnosis is the essential basis in the cure and prevention of disease, the better; and we should accordingly greet with approval any discovery whatsoever which may facilitate this end, even if it does appear that we are departing from our beaten track. As Simon says in the preface to his work on clinical diagnosis, "The time is at hand when the practice of medicine is becoming what it was long ago, but then unjustly called a true science and art. No continuing success can be built upon empiricism, or upon the proportion of guess-work, which is inseparable from dependence upon the experienced eye. 'Diagnosis' is now the password in medical science."

Even though the science of diagnosis by laboratory methods is yet in its infancy, we are already dependent upon its existence to such a degree that we can scarcely realize how great a step backward its withdrawal would represent. It may and can be said, by some, that they have done well without this help in the past; but we are not living in the past. The successful doctor of to-day must be industrious, thorough and painstaking in all that he does. We, as homœopaths, realizing, as only homœopaths can, what a bulwark we have in our law of therapeutics, are prone to be too well satisfied with

this, and I fear do not keep abreast of the progress being made in the science of medicine, as pertaining to diagnosis. (I do not wish to be considered as saying that all of those of the opposite school do.) This we cannot afford, for we can certainly continue to be good homœopathists, and yet (as one of our members has said) not allow the merest tyro in medicine to make a diagnosis where we have failed, and especially when the failure is due to the fact that we have not kept pace with the advances made in the science of diagnosis. It injures us as homœopathists and as individuals, when this occurs.

The scientist must of necessity be a revolutionist; and, to again quote from a recent address by a member of this society: "The present is an age of revision—an age of revision of creeds and dogmas. From time to time it becomes necessary for older theories to readjust themselves to the increased and more positive knowledge of the day." In the time of Hippocrates there were no clinical laboratories. In fact, our advancement in this branch of medical science dates back but a few years. But so familiar have we become with the many laboratory appliances now in use, that one almost forgets that there ever was a time when we did not possess them. A study of the ancient medical writings will disclose that the ancients not only examined the pulse and tongue of the patient, but the ejecta, consulted the stars, the flight of birds, noted any incidental occurrences during his visit, and made his prognosis (for which they seemed particularly to care) from a multitude of varying circumstances. They paid great attention to the character of urine in disease, and their knowledge of the subject will be admitted even at the present day to have been remarkable. A method of examining the urine was by letting fall from the end of a straw a drop of oil into the patient's urine. If the oil was precipitated and attached itself to the bottom of the vessel, they predicted an unfavorable result; if, on the contrary, it floated, they gave a favorable prognosis. This is, so far as it is known, the earliest recorded way of testing the specific gravity of the urine.

While diabetes was known to such early writers as Celsus, Aretæus (1st century), Galenus (131 to 210 A.D.), it was Willis who in 1674 first associated the presence of sugar with the disease, which he discovered from the sweet taste of the urine;

and this method of tasting the urine was the common practice among the older physicians, particularly in matters of prognosis, and it continued a routine method of examination until the beginning of the 19th century. In those early days, also, great significance was attached to the examination, and a great deal of importance given to the configuration, of the sputum. It was spoken of by different names, according to its appearance, viz.: as sputum crudum, sputum nummulare, and sputum globosum. The nummulare sputum especially was thought to be quite characteristic of pulmonary tuberculosis—a view which accords quite well with our own experience, in so far as its appearance has reference to the third stage of phthisis. We have evidence, also, that the ancients in their way examined the blood. The appearance of the crusta phlogistica was thus always noted when bleeding; and of this method we know to-day that it was nothing more nor less than a crude way of estimating the number of the leucocytes, and that in pneumonia the prognosis was based upon the extent of the leucocytosis. The *rationale* of this is well borne out by our present knowledge.

These methods were crude, and depended upon the ordinary senses and unaided eye; but with the invention of the microscope an entirely new field was opened up. To us who are living to-day it is scarcely conceivable what an advance the discovery of the microscope represents. But for its use many of the causes of disease, well known to-day, would be undiscovered. By its aid, Davaine in 1863 discovered the bacillus of anthrax. Next discovered were the bacilli of relapsing fever and leprosy. The bacillus of typhoid was discovered by Eberth in 1880, and artificially grown by Gaffey in 1881. Of equal importance was the discovery by Klebs and Loeffler of the bacillus of diphtheria, and of the tubercle bacillus by Koch.

Allow me here to recall to you the method of diagnosing pulmonary tuberculosis prior to the discovery of the tubercle bacillus. First, the character of the cough was considered. I find that one author (and not an old one, either) describes the cough at great length, only to end with the remark that the cough has no especial characteristic which will distinguish it from the cough of bronchitis; and the same statement is made

in reference to the appearance of the sputa. Hæmoptysis was considered about the earliest really suggestive symptom of pulmonary phthisis. When Laennec introduced the science of physical diagnosis, a great step was made toward the earlier diagnosis of pulmonary tuberculosis; and yet the most experienced diagnosticians were at times in error. The finding of elastic tissue (which as a method of diagnosis antedates that of the search for the tubercle bacillus) shows that there exists a destructive lesion of the lung, but does not indicate the character of the lesion.

With the discovery of the tubercle bacillus another great step was made. As its presence in the sputum proves positively the existence of tuberculosis, and as it may be found before the physical signs are at all definite, an examination in this direction is now regarded as indicated in all cases in which the slightest suspicion as to presence of tuberculosis exists. I wish to insist that the physician who does not avail himself of this, the most important aid in the early recognition of tuberculosis, is guilty of a serious lapse in his obvious duty to his patient and to the public. It is here that the clinical laboratory steps in; the private clinical laboratory of the physician or that of the community. Inability on the part of the physician to make the requisite examination can no longer be an excuse. You may ask whether it is possible to demonstrate the presence of the tubercle bacillus in every instance where tuberculosis exists, and I shall be obliged to answer, No; but the percentage of such negative cases can scarcely be said to exceed one-half of 1 per cent., and in this small number of negative cases it is quite likely that a positive result might be obtained if recourse were had to the animal experiment. What the future will bring forth in this matter of early diagnosis of phthisis it is difficult to say; but recent investigations with the X-rays have already yielded results which make me believe that ere long we shall see the day in which the diagnosis of pulmonary tuberculosis may be possible before the appearance of bacilli in the sputum, or, for that matter, before there is any sputum.

Quite as important as the search for tubercle bacilli in suspected cases of phthisis is the search for the organism of diphtheria in doubtful cases and in the absence of a clear clinical picture; and here, as there, the physician who refuses to avail

himself of the laboratory methods in the early diagnosis of this disease is guilty of serious neglect of his obvious duty to his patient and the public.

In the summer all of us meet with certain cases of diarrhœa which are characterized by their great severity or great protraction, and so merit the diagnosis of dysentery. In many of these cases, which too often end fatally, an examination of the feces and a recognition of the cause of the dysentery would have saved life. I refer more particularly, in this connection, to that form of dysentery which is produced by the *amœba coli*; and I make the statement emphatically that the early recognition of the character of the dysentery may save the life of the patient, because our ordinary forms of treatment in this particular form of dysentery are notoriously unsatisfactory.

Not long since I noticed the report of a case of pernicious anæmia, in which the autopsy showed the presence of one of a dangerous animal parasite which is capable of causing one form of the disease in question. The writer himself admitted that the life of the patient would in all probability have been saved had he recognized the presence in the stool of the eggs of the parasite, which actually existed there in large numbers.

The importance of laboratory methods in the diagnosis of malarial fevers is already too well known to you all to require lengthy comment. To be sure, there are some few who maintain that they are able to make a differential diagnosis between that protean array of other diseases and atypical forms of malarial fevers; but to these I will only say that I fear they fail to make a correct diagnosis in many cases, and that a more liberal use of the autopsy knife in their fatal cases might probably prove of value.

Of incalculable value, both from the standpoint of diagnosis and prognosis, is the relation existing between inflammatory diseases and leucocytosis. Generally speaking, the increase in the number of the leucocytes is here directly proportionate to the intensity of the local reaction; where this is slight, the leucocytosis is slight; where it is extensive, the more marked the leucocytosis. In pneumonia, for example, we may meet with grades of leucocytosis which are excelled only in extent by that observed in the various types of leukæmia. All of you are aware of the great difficulties which so often attend the diag-

nosis of acute croupous pneumonia in children. The child suddenly becomes sick with ill-defined symptoms. The temperature is high, the pulse rapid, and the respiration is increased, but often only in indirect proportion to height of fever, and the physical examination is negative. The first day passes, the second, third, fourth, fifth, and even a greater length of time may elapse, before a diagnosis of the disease becomes possible from ordinary methods of investigation. Holt tells us that in 40 per cent. of all cases of infantile pneumonia the appearance of the physical signs of the disease is greatly delayed, and may, indeed, not occur until the day of the crisis. In just such cases the value of blood examination is at once apparent, as the existence of a well-marked leucocytosis in such cases will probably always give the diagnosis; and I may say the prognosis as well; for it is noteworthy that the absence of a leucocytosis in severe pneumonia will probably always admit of a fatal prognosis. In these latter cases we must imagine that the toxæmia is so intense from the very beginning that a healthy reaction does not occur at all. Unfortunately we are not able to state definitely the converse, that recovery will take place in those cases in which a leucocytosis exists; but we may say that such cases have at least a chance, while in the absence of leucocytosis there is none.

In appendicitis the leucocyte count is one of the most important aids to diagnosis. All of you have, no doubt, met with cases in which the early symptoms of the disease closely simulated those of appendicitis, but in which the future course of the malady showed that the disease in question was in reality a typhoid fever. A leucocyte count in such cases would help clear the difficulty, as uncomplicated typhoid fever is not associated with an excessive number of leucocytes, while this is the rule in appendicitis.

Some have attempted to formulate a rule by which the blood examination may serve as the basis in determining the necessity for an operation; and it has been advocated that surgical interference should take place whenever the number of leucocytes reaches 15,000 to 20,000. Personally, I am opposed to any such arbitrary rule, but I am willing to admit that a patient presenting a leucocytosis of 15,000 to 20,000 should be operated upon without delay. There are cases, however, in which oper-

ative interference is urgently called for, even though the number of leucocytes be but little above 10,000. I fear that many surgeons have not paid sufficient attention to what would be the normal number of leucocytes in individual cases. As is well known, this varies between 3000 and 10,000 per cm., the exact number being primarily dependent upon the state of nutrition of the individual. Given a thin, puny, poorly-nourished subject, with the physical symptoms of appendicitis, I should personally regard the presence of 10,000 to 12,000 leucocytes as sufficient indication for operative interference; for in such a case we could directly assume that from 3000 to 4000 would represent the maximum normal number, and that 10,000 to 12,000 would manifestly represent a large increase. On the other hand, given a robust and well-nourished individual, in whom we might ordinarily expect 8000 to 10,000 to be normal, 12,000 would only represent a very moderate increase, and in such cases delay would be admissible.

I wish to call your attention to one more method of combined surgical and laboratory method of diagnosis, and that is, the diagnosis of the various forms of cerebro-spinal meningitis by means of the examination of the fluid that has been withdrawn by lumbar puncture. This method I regard as one of the most important, and one that should become the common property of the physician at large; for by its aid the differential diagnosis between the tubercular form of meningitis and the epidemic forms is readily effected.

In the latter case it is possible to demonstrate the presence of the diplococcus intracellularis, which is found outside of the cells in the earlier period of the disease, and more frequently within them as the disease progresses; while in the tubercular form you will encounter tubercle bacilli, or, equally important, large numbers of lymphoid cells. The presence of these is, indeed, quite characteristic.

With the more skillful use of the microscope and the development of our knowledge of physiological chemistry, the examination of the urine means something more than the mere determining of the presence or absence of albumin and sugar. While only a few diseases can be diagnosed by the urine alone, many diseases produce changes in the urine which, when taken into consideration with other symptoms, are of great value, both

in diagnosis and prognosis. For example, the diazo-reaction will be found of great diagnostic value in typhoid fever. I have found it, when taken in consideration with other symptoms, as reliable as the Widal; and, furthermore, a positive reaction is often present before the Widal reaction can be obtained. Its value as to prognosis is well shown by Michealis (*Deutsche Med. Woch.*), who says Clemens notes that of 100 cases of phthisis which ended fatally, 87 showed the diazo-reaction. Rutemyer obtained positive results in 85 out of 106 which died. Of 13 cases of acute tubercular pneumonia, Frankel found positive reaction in 11. Grundriss states that in his fatal cases of phthisis, the reaction was present without exception. Michealis, who was really the first one to study systematically the relation of the diazo-reaction to tuberculosis from the standpoint of prognosis, reports that of all the cases of phthisis which were admitted to Berlin Charite with the Ehrlich reaction well marked, 80 died, 13 were discharged unimproved, 3 were transferred to other hospitals, and 15 left the hospital improved. In other words, in these 111 cases, a fatal result was known to have occurred in 72 per cent. Stadelman states that of 38 other cases with positive reaction, 28, or 75 per cent., died in the hospital; the subsequent fate of the remaining cases was not ascertained, but I think we may well assume that of these, at least 50 per cent. died. We may accordingly formulate the general rule that a fatal result in pulmonary tuberculosis may be anticipated in about 85 per cent. of all cases of phthisis in which a positive diazo-reaction is obtained. The fatal end may be expected to occur within six months after the time when the persistent reaction is established. The importance attributed to the diazo-reaction by the Germans, from the standpoint of prognosis, is further illustrated by the fact that no patient who presents the reaction is treated with tuberculin at the institution for infectious diseases at Berlin, for the reason that such cases are regarded as hopeless. The consensus of opinion among German physicians is that no cases of phthisis presenting the Ehrlich reaction should be admitted to public sanatoria.

In diseases of the stomach, laboratory methods are practically essential to a correct diagnosis. How anyone can rationally treat a digestive disease without a careful and painstaking examination of gastric contents I personally cannot understand;

the entire question of treatment can be nothing but pure guess-work. I do not wish to say, of course, that we shall pump out the stomach in every nervous individual who comes to us complaining of a full feeling, and of gases which will pass neither up nor down; but I do wish to insist upon the necessity for an elaborate chemical examination of the stomach contents in all those cases in which, after the forty-fifth or fiftieth year of life, there is noted an acute onset of dyspeptic symptoms associated with slight loss of flesh, and in which the conditions persist beyond two or three weeks at the longest. The only chance which your patient with cancer of the stomach has depends upon your early diagnosis; and long before any tumor can be felt or loss of flesh has gone on to an extreme degree, it is a safe rule that an exploratory incision be made in all those cases in which a careful chemical examination of stomach contents reveals an absence of hydrochloric acid, and the presence of lactic acid in notable amount. Even should it be shown that your diagnosis has not been made sufficiently early to warrant an extensive resection of stomach, you may at once proceed with gastro-enterostomy, and in that way at least save your patient much suffering, even though the disease must ultimately prove fatal.

It seems only yesterday since we read our first account of the wonderful properties of the X-rays. Yet every one has come to know a little at least of the high vacuum Crookes tubes, and the peculiar glow that comes from them when electrified. While many of the hopes entertained at the beginning have not been realized, the X-rays have in many ways become of great value as an aid to diagnosis. I have already mentioned their possible value in the diagnosis of pulmonary tuberculosis. By their use the presence of intrathoracic tumors, the diagnosis of which, by the ordinary methods of clinical examination, is often very difficult, if not impossible, may be made comparatively easy. The same may be said of their value in determining the presence or absence of biliary or renal calculi, which you all know are often most difficult of detection by the usual method of diagnosis. Their use in determining bone lesions has become a matter of such frequent occurrence that it is useless to more than allude to it.

I fear very much that I have already consumed too much

time in this address; but before closing I wish to call your attention to one more method, and that is the valuable aid derived from a microscopical examination of uterine scrapings in suspected cases of cancer, and, in fact, in all cases of hæmorrhage occurring particularly about the menopause. It is often by the microscope alone that a positive diagnosis can be made, and the latter must be made early in the disease if we can hope to benefit our patient at all.

It must be remembered, above all things, that the clinical laboratory is an aid to diagnosis, but rarely can it alone furnish a conclusion; and, therefore, in all cases I enjoin you to carefully consider together the evidence afforded by the clinical history, the physical examination, and the clinical laboratory.

SOME CASES OF PERNICIOUS ANÆMIA, WITH COMMENTS.

BY L. S. LUTÓN, M.D., GRAND RAPIDS, MICH.

Ex-Interne, Cook County Hospital, Chicago, Ill.

IN recent years, as the subject of hæmatology has become more familiar to the practitioner, many cases of pernicious anæmia are being reported from various quarters. The following histories are given to illustrate, in a general way, the blood-findings and course of this deep-seated malady.

CASE 249,660; aged 60. Irish. Present illness: One year ago patient began to feel weak, tired easily, and slight exertion would bring on dyspnœa. Has at various times suffered from nausea, vertigo, palpitation, and the hands for one year past have felt stiff and prickly. Has lost a good deal in weight, and expectorates occasionally a muco-purulent, blood-streaked substance. At times, sweats at night.

Previous history: Has had no such illness before.

Habits: Always a heavy drinker of whiskey and beer.

Examination: Patient well nourished, and is somewhat irrational at times. Conjunctivæ very anæmic. Lungs: Breath-sounds weak. Heart: Soft systolic murmur at apex not transmitted; pulse is soft and regular. Abdomen: No splenic or hepatic enlargement. Skin: Pallid, and a few ecchymoses are

present. Urine analysis: 24 hours; amount, 640 c.c., 1020; urea, 11.5 gms.; acid, total solids, 28 gms.; albumin positive, glucose and bile negative. Microscopical: Pus, hyaline and granular casts. Eye ground: Disks slightly hyperæmic, outlines distinct, vessels normal. June 27, 1901. Blood examination: Hæmoglobin, 36 per cent.; specific gravity, 1040. R. B. C. hæmatocrit, 2,000,000. R. B. C. count, 1,345,000. W. B. C., 4500. Smear, marked poikilocytosis and polychromatism. Differential count of 500. S. mononuclears, 38 per cent. L. mononuclears, 2 per cent. Polymorphonuclears, 57 per cent. Eosinophiles, 2 per cent. Myelocytes, 2. Nucleated reds: Microblasts, 2. Normoblasts, 2. Megaloblasts, 6. Color index, 1.33. Volume index, 1.56. July 5, 1901. Hæmoglobin, 27 per cent. R. B. C. hæmatocrit, 2,000,000. R. B. C. count, 1,424,000. W. B. C., 9000. Megaloblasts. Color index, 1.35. Volume index, 1.40. July 13, 1901. R. B. C. hæmatocrit, 1,900,900. R. B. C. count, 2,400,000. Volume index, 1.26. Smear shows no nucleated reds.

In this history we have all the classical symptoms of a severe anæmia existing for over a year, and the examination reveals nothing to satisfactorily account for it. The blood, however, shows many of the features usually seen in the so-called pernicious anæmias, namely: Hypoleucocytosis, small number of reds (between one and two million), low hæmoglobin, but a high-color index, signifying the richness of hæmoglobin in the individual cells, nucleated reds, the megaloblasts predominating, and a few myelocytes. The volume index, obtained by dividing the R. B. C. hæmatocrit by the R. B. C. count, is high, indicating in a general way the increase in the size of the red cells. The patient remained in the hospital only a short time, but began to improve before she went out, and the color index seemed to be approaching the normal.

CASE 251,939; aged 57. Laborer. Irish. Habits: Heavy drinker and smoker. Present illness began two months ago with a diarrhœa, and the stools were yellow and frequently blood-stained. Vomited after drinking cold water especially. Has lost weight, feels weak, and gets out of breath very easily. Examination: Patient is well nourished, pale and slightly icteric. Cerebration dull, and patient is at times irrational. Tongue is large, flabby and very pale. The heart shows some

hypertrophy, and the apical impulse is forcible, but irregular. A harsh, apical, systolic murmur, transmitted into the axilla, is heard. Second pulmonic is accentuated. The liver is slightly enlarged and the superficial veins prominent. Pulse full and irregular; arteries markedly sclerotic. Patient was very weak on admission; gradually lost consciousness, with severe dyspnoea. Petechial spots are present all over the body, and blood constantly oozes from nose and mouth. Urinary analysis: Yellowish, acid, 1030; albumin positive, sugar and bile negative. Microscopical: Pus, granular, hyaline and epithelial casts. Blood examination: R. B. C. hæmatocrit, 400,000. R. B. C. count, 420,000. W. B. C., 4700. Hæmoglobin, 9 per cent. Color index, .88. Volume index, 1.05. Smear, megaloblasts and normoblasts. Anatomical diagnosis post-mortem: Cardiac hypertrophy and dilatation, pleuritis, myocarditis, hepatitis, endocarditis, mitral and tricuspid, interstitial splenitis, and nephritis.

CASE No. 250,444. Present illness began two months ago, with œdema of legs and hands, dyspnoea, vertigo, and pain in sternal region; has had a pain in the eyes and dim vision for one month. The examinations show a slight hypertrophy of the left ventricle, and an accentuated aortic sound. The radial arteries are tense. The œdema of the extremities extends as far as the knees. Urine analysis: Clear, limpid, 1007, acid; albumin positive, sugar and bile negative. Microscopical: granular and hyaline casts. The treatment in this case was eliminative, and the patient left the hospital in two weeks' time, feeling comparatively well, but returned in seven or eight days. On his admission he was very dyspnoeic, drowsy, and the eyesight was very poor. Blood count, R. B. C., 1,669,500; W. B. C., 9800. Hæmoglobin, 20 per cent. Color index, 606. Slight poikilocytosis, few megaloblasts, and normoblasts. The urinary examination showed the same evidence of nephritis as existed before.

These two cases are here introduced to show how easy it is to be misled in the interpretation of the blood findings. Particularly in pernicious anaemia is it quite essential to have several examinations made over a more or less lengthy period of time. The patient whose history has just been cited died from uræmia, and the anaemia present was due in a large measure to

the existing nephritis, yet the blood showed a short time before death the presence of normoblasts and megaloblasts. It will be noticed, however, that while the hæmoglobin and red count are both low, the color index is not high, a point of great importance in differential diagnosis, and in the one case in which the computation was made the average diameter of the red cells was not far removed from normal. In addition, neither of these cases gave a history anything like that of pernicious anæmia, and the post-mortem examination certainly did not show any of the characteristic changes. The finding of a few nucleated reds does not by any means stamp a case as one of pernicious anæmia.

The following case is given more in detail, as it was to me the most satisfactory one to follow of any coming under my notice. He was in the hospital during his three exacerbations, and died during the third attack.

CASE 228,561; Swede; aged 30. Laborer. Family history: Father alive and healthy at 80 years of age. The rest of the history is negative. Habits: Drinks an occasional glass of beer. Used to smoke and chew, but has stopped both. Occupation: Works on a farm in the summer time, and in lumber camps in the winter. Present illness: Up to five weeks ago, patient was a strong, healthy man. At that time he was taken sick with pain and soreness in back and across the chest. Has had some headache, but no angina or hæmorrhages. Appetite has been good, but he has vomited considerably. Bowels move once a day regularly, but has an occasional pain across the upper part of the abdomen. Is troubled by a ringing in the ears which throb, and the hearing is dulled somewhat. Dyspnœa and palpitation of the heart on exertion continues up to the present time. Is growing weak, so that he cannot walk very far. Thinks he has lost about twenty pounds in weight. Has occasional night-sweats, but sleeps well. Two days before coming to the hospital his hands and face began to puff, but were not red or painful. Has noticed that since soreness in back came on his skin has looked yellowish. Examination: Development good, but poorly nourished, very pale, mind clear, lies quietly and in no distress. No dyspnœa or cyanosis present. Conjunctivæ pale, sclerotics pearly white. Pupils negative. Range of ocular muscles normal, and no paralyses pres-

ent. Tongue broad, flabby, and coated white. Mucous membranes pale and moist. Teeth show a gray deposit, and the gums are very anæmic. Chest: This is well developed. Expansion and excursion are good. Over right apex posteriorly there is present slight dullness and mucous *râles* heard during both inspiration and expiration. Heart: Apex-beat faint, no murmurs. The pulse is soft, small, and of a low tension. Abdomen and genitalia are both negative. The extremities show dilated veins over the left leg. Lymphatics: Cubital and inguinal glands are palpable. The muscles are flabby and the bones smooth. Skin: Moist, muddy yellowish color; loose, cool and elastic. Vomitus: Watery, greenish-yellow. May 15, 1900. Blood examination. Hæmoglobin, 25 per cent. R. B. C., 932,000. Color index, 1.3. Poikilocytosis, June 4, 1900. Hæmoglobin, 22 per cent. R. B. C., 784,000. W. B. C., 2100. Color index, 1.4. June 30, 1900. Hæmoglobin, 65 per cent. R. B. C., 3,500,000. Color index, .9. During his stay in the hospital of about three months, the patient had no temperature excepting for three or four days. He felt strong when he went out, and worked for about three months, but the old symptoms returned, and on his second entrance into the hospital was suffering from dyspnœa, languor, headaches, vertigo, anorexia, vomiting, and sternal pains.

Examination shows the development to be good, but the body is poorly nourished. The skin and mucous membranes are very pale, and the face is flushed. Patient is slightly deaf in both ears. Heart: Apex-beat not palpable, no cardiac murmurs, systolic soft murmur heard over the carotids. Abdomen negative; the muscles are soft and flabby. Pulse is weak and rapid, but regular. January 2, 1901. Temperature 100–101°. Slight epistaxis. January 9, 1901. Hæmoglobin, 25 per cent. R. B. C., 1,376,000. W. B. C., 3000. Color index, .9. Normoblasts and megaloblasts, microcytes and macrocytes, poikilocytes. January 11, 1901. Persistent epistaxis. January 23, 1901. Epistaxis, vomits very easily. January 31, 1901. Spots before eyes, night-sweats. February 6, 1901. Temperature 104–105°. Otitis media. March 3, 1901. Marked anæmia, voice weak, mucous membranes very pale, sternal pains, tongue coated white, subcutaneous œdema. Heart sounds are weak, and present hæmic murmurs. March 4, 1901. Temperature

normal, being the first time since coming into the hospital. March 27, 1901. Hæmic murmurs heard all over the cardiac area, and the face is flushed. April 1, 1901. R. B. C., 3,000,000. May 14, 1901. Hæmoglobin, 63 per cent. Specific gravity, 10.58. R. B. C. hæmatocrit, 3,575,000. R. B. C. count, 3,600,000. Color index, .87. Volume index, .99. Moderate poikilocytosis. W. B. C., 9000. Normoblasts, 6. Megaloblasts, 2 in a thousand count. A few myelocytes were noted. A few days from this time the patient left the hospital feeling fairly well, but in two or three weeks he returned with a very severe grade of anæmia, and at this time the urine showed a trace of albumin, and a few granular and hyaline casts. Blood examination: R. B. C., 925,000. W. B. C., 1720. Megaloblasts and normoblasts. During this time the patient ran a temperature of from 99–102°. Had marked gastric symptoms, and became very dyspnœic just prior to his death.

When this man first came to the hospital he had his anæmia well developed, and he gave a splendid account of the signs and symptoms noted from to time by himself. There is nothing in the family history or previous illness that throws any light on the etiology. His occupation was a hard one, both in the winter and summer. The onset was somewhat more acute than we often have it. The severe anæmia noted in the first blood-count made in six weeks' time showed very marked improvement, and the patient was able to resume his occupation for about three months, at the end of which time the old symptoms again returned. He came back to the hospital, and the blood examination showed in a general way the same changes noted at his first admission. His stay at this time lasted for about six weeks, and at his worst it would seem as though he could not live; but a slow improvement set in, and he was again able to be up and around, his blood-count becoming fairly satisfactory. He stayed out of the hospital about six weeks, and coming back, died three weeks afterwards. Very unfortunately, a post-mortem could not be obtained.

The person following a case like this cannot help being impressed with the necessity for a guarded prognosis, for almost inevitably the apparent return to health is in a variable time followed by the old symptoms. Some patients have as high as five of these remissions. When a great many corpuscles are

counted in the stained preparations, almost invariably the megaloblasts predominated over the normoblasts; but as an improvement in the general condition was noted, more normoblasts made their appearance, signifying an active regeneration on the part of the bone-marrow. In this form of anæmia the color and volume index is high, and with a general improvement both of these approach the normal. An experience with several of these cases, ante- and post-mortem, has impressed me with the toxic theory of their causation. Undoubtedly the time will come when we will know this etiological factor, and another so-called blood disease will be relegated to the increasing group of secondary anæmias.

THE USE OF THE IODIDES IN THE TREATMENT OF MENINGITIS.

BY W. K. INGERSOLL, M.D., PHILADELPHIA.

SOME ten or twelve years ago, after having had some bad results in the treatment of meningitis, I interestedly took up the study of the disease, getting all the information I could on the subject. At the end of my research it seemed that I was no better off, as far as its cause and treatment were concerned, than I was before.

A short time after this came the report of Flexner and Barker, of Johns Hopkins, on an outbreak in a small town of Maryland, and, if my memory serves me, I concluded from that report the probable cause of the disease was the diplococcus lanceolatus.

I had had a bad case of pleurisy of the diplococcus variety, which was relieved by the internal administration of some of the soluble iodides, after testing with several remedies. Then a case of pneumonia, with an arthritis of the elbow on the same side, with such an effusion that there was a pendulous swelling as large as a baseball. Under the administration of an iodide, and painting the part with tincture of iodine, the inflammation disappeared in a very short time. Another case of peritonitis, with high temperature and swollen abdomen, was followed by a marked meningitis, and relieved by iodide of potash. Then I had a case of complete paraplegia, and

almost complete loss of sight, with great injections of conjunctiva and sclerotic. He being a man about town, I supposed it was of specific origin, and gave large doses of iodide of potash, with return of motion, beginning in the fingers and toes on the eighth day, with rapid recovery. After reviewing this case, I considered it one of meningitis, and without any specific basis.

The foregoing, with other instances of diplococcus inflammation, made me consider the soluble iodides as a remedy in this most serious disease, and I determined to use one in the next case that occurred in my practice. This was not long in making its appearance.

A young man, twenty-three years of age, had a most typical case. Dr. Goodno saw the case in consultation. Ninety grains of iodide of potash a day relieved the symptoms in forty-eight hours; discontinued the remedy, and in twenty-four hours the patient was in the midst of the delirium again; when, re-administering, the iodide brought the case out to recovery. I also had a case in a child seven years old, and one in a girl fourteen, which were likewise cured. The past week a case of a young woman of eighteen, to whom I was called on the sixth day of the disease, and found spots on the legs and arms well marked, fluid in the lateral ventricles of the brain; no sight, no hearing, both arms paralyzed, involuntary micturition and defecation. One hundred and twenty grains a day of iodide of potash brought recovery in one week. This last case is the most marked, as showing the value of a soluble iodide. For six days the disease was piling up its poison in the body, until it seemed to almost control the vital processes.

Whether iodide of potash has a specific effect upon the germs, or whether it combines with the toxine formed, and gets it out of the body rapidly, I do not know; I am inclined to think both effects may play some part.

I want to say these cases were probably not of the epidemic cerebro-spinal variety, due to the micrococcus intra-cellularis, but sporadic cases, due to the diplococcus.

LOOSENED TEETH.—In patients suffering from the effects of violent blows upon the jaws, never remove a tooth just because it is loosened. Its tendency is to become again firmly attached, and hence it is always best to wait.
—*Med. Era*, Aug., 1902.

THE DISORDERS OF THE THYROID GLAND.

BY J. E. BELVILLE, A.M., M.D., PHILADELPHIA, PA.

(Annual Address before the W. B. Van Lennep Clinical Society.)

It would be impossible, except in the limits of a book, and that of considerable dimensions, to exhaustively treat of my subject in all its bearings. I wish to preface what I have to say with this remark, as, necessarily, much of great interest must be passed over in an apparently superficial manner.

The thyroid gland is developed from three separate rudiments—or, a median and two lateral. The median rudiment is developed from an evagination of the epithelium covering the floor of the pharynx, beginning as a small pouch, which gradually expands laterally, preserving its connection with the pharynx by means of its median duct up to the end of the eighth week. The opening of this duct, the thyroglossal, upon the surface of the tongue corresponds with the foramen cæcum. The abortion of the duct begins about the fifth week, and is complete by the end of the eighth week. In the higher vertebrates there is no connection in extra-uterine life between the gland and the pharynx. In a few of the lower animals the connection persists, and the secretion of the gland is poured into the pharynx. From these two facts it has been argued that the ductless glands, of which the thyroid may be taken as a type, represent more highly-differentiated structures than those glands whose excretory ducts remain patent throughout life: and it is highly probable that as at one period, in all animals, the secretion is discharged into the pharynx, it is unaffected in its properties by the action of the digestive ferments, and hence the administration of the gland in substance, or an extract from it, is effective.

The two lateral rudiments are formed from the epithelium of the fourth gill-clefts, forming closed vesicles entirely shut off from the pharynx. In their further development these three rudiments gradually approach each other, and union of the three takes place about the end of the seventh week. This makes two stages in the development of the gland. The first,

extending up to the end of the second month, consists of epithelial budding, with the formation of solid cords of epithelial cells, which are surrounded on all sides by connective tissue. In the second stage these cords become hollowed out, and show a narrow central lumen. Later, constrictions of these tubular spaces begin to appear, becoming more and more distinct, until, finally, closed vesicles or follicles are formed, as seen in the fully developed gland. At the same time, according to Woelfler, there is a remarkable development of blood-vessels. This development is so considerable that Müller says, and with reason, that a child's thyroid resembles an angio-sarcoma, so rich is it in blood-vessels.

Anatomy.—The fully-developed gland consists of two lateral lobes, united near their lower border by an isthmus. Streck-eisen found, in 79 per cent. of all cases, a process of the gland known as the processus pyramidalis. It is attached, in order of frequency, to right lobe, left lobe or isthmus. Accessory or aberrant thyroids are also described lying near the hyoid bone, in all probability formed from portions of the gland cut off during its descent in the developmental stage. Lying outside the capsule of the thyroid on either side, and having a separate capsule of their own, are two kidney-shaped bodies, known as the parathyroids of Sandstroem, who was the first to describe them. They are attached on either side to the external borders of the lobes of the thyroid, and are made up of small masses of compact epithelial cells, arranged in nests and lobulated. The connective tissue is small in amount; blood-vessels large, and running in the stroma. They present the same appearance as the fœtal gland prior to the development of acini. I have described them at length because of their importance, as in them probably lies the foundation of the successful removal of the thyroid without the production of unfavorable after-symptoms. Biondi observed that intracapsular enucleation could be done without a following cachexia thyreopriva. It was undoubtedly due to the fact that by this method the parathyroids were not removed.

The gland lies in close juxtaposition to the trachea. Each lobe extends from the fifth or sixth ring of the trachea below to the side of the thyroid cartilage above, and is two inches in length by one and one-quarter inches in breadth. The isthmus

is variable in size, shape and position, and usually crosses over the second and third rings of the trachea. The weight of the gland is about two (2) ounces. The whole gland is held in close relation by its fibrous investment, and by the deep cervical fascia to the trachea, so that the gland rises and falls with the larynx in swallowing. Its blood supply, which is remarkably rich, is derived from the superior and inferior thyroid arteries, with occasionally a branch from the innominate or arch of the aorta, known as the thyroidea ima. The veins, too, are remarkably large, and form a plexus upon the lobes of the gland, the superior and middle emptying into the internal jugular; the inferior communicate with each other freely over the trachea and empty into the innominate vein.

Histology.—Histologically, the gland is made up of a large number of bladder-shaped vesicles or acini, between which run the blood-vessels, lymphatics and nerves. The acini are lined with a single layer of cylindrical epithelial cells, having oval nuclei, and surrounding a lumen filled with the secretion of the cells. Trabeculae of fibrous tissue run in from the investing capsule of the gland and subdivide it into lobules. A complete distinct membrana propria is not always to be demonstrated. Schmidt declares that the epithelial cells lie directly upon the blood-vessels, or separated by, at most, a few fibrils of connective tissue. Other authorities describe a distinct membrana propria. It, however, does not seem to entirely surround the acini, but to be wanting at one point.

The epithelial cells are cubical or cylindrical, but vary very much in height, as the acinus is stretched or relaxed. When the stretching is excessive, the cells are flat, resembling endothelium, their nuclei projecting into the lumen of the acinus. Languedorf describes two forms of cells—the chief and the colloid cell; chief cells being in the majority, and distinguished by a more homogeneous, glistening, hyaline appearance, and by deeper staining. They are, however, according to Schmidt, simply differing physiological conditions of the same variety of cells. Hürtle describes intercellular spaces, through which the secretion of the cells is discharged into the surrounding lymph spaces. Müller and others believe these spaces to be shrunken cells.

The blood-supply is very rich, being distributed through the

larger trabeculae of the stroma, and sending capillary branches which anastomose between the acini, so that the circulation of the thyroid may be likened to that of the lung. The capillary branches at some points in the acinus lie directly beneath the epithelium. The lymph vessels are also numerous, and lymph spaces have been demonstrated surrounding the acini.

According to Kölliker, the only nerve supply is that to the vessels. Parameschko was the first to call attention to the fact that the thyroid was rich rather than poor in nerves. Using the Ehrlich and Golgi stains, Crisafelli demonstrated a plexus of nerves surrounding not only the blood-vessels but the acini as well. From these plexuses end-branches are sent out which terminate on the outer surface of the epithelial cells; that is, the side away from the lumen. Anderson has demonstrated that the thyroid is as richly supplied with nerves as with blood-vessels. The vaso-motor nerves form rich plexuses surrounding the blood-vessels, sending branches which run to the media of the vessels. The branches to the acini form a rich plexus surrounding the acini, and fine branches from the plexus pierce the acinus, and end in button-like enlargements at basal end of epithelium.

Physiology.—The colloid contents of the acini are generally considered to be the result of a true secretion formed in the cells, and not the result of degenerative changes in the cells themselves. The process is described by Müller, as follows:

The epithelial cells, whose granules are scarcely visible under oil immersion, take up fluid from the blood-vessels, giving a more distinctly granular character to their contents. This increased cell-content pushes the cell wall into the lumen of the acinus. On such large and swollen epithelial cells now and then a large drop is seen, but usually the colloid contents of lumen lie directly upon the cells. Sometimes a small, scarcely visible drop is seen. As this enlarges, the cell shrinks, and, for a time, the extruded drop, on account of its different density, is visible in contents of acinus, but gradually merges; after extrusion of its secretion the cell often becomes so small as only to be recognized by its nucleus. It is this condition which has given rise to the idea that intercellular spaces exist. That the colloid material finds its way out of the acini seems to be demonstrated by the fact that it is said to be found filling

the surrounding lymph spaces. Other authorities deny its presence in lymph spaces. Definite facts to demonstrate exactly in what manner the discharge of colloid takes place are still lacking. Indeed, the only way in which to harmonize the conflicting views seems to be to consider that the more solid portion of the colloid remains within the acini, and is not discharged from them, but that the cells take up fluid from the blood-vessels, that chemical changes take place in this more fluid portion, and that it is reabsorbed by the vessels.

The most fanciful suppositions were entertained regarding the function of the thyroid gland until the results of experimental removal in animals and therapeutic excision in man had demonstrated that it had a very important part to play in the human economy. So early, however, as the beginning of the nineteenth century Hofrichter took the ground that the function of the thyroid was not, as belived at that time, to act as a diverticulum to relieve the cerebral circulation, but that its secretion acted upon the blood chemically.

Concisely stated, the theory obtaining at the present time is that its function is the removal of an entero-toxine in the blood through its transformation into tox-albumin, and its conversion into a non-toxic compound of albumin by combination with iodine, or in the prevention of the formation of injurious compounds of iodine through organic union to form thyroïdin, the active constituent of the thyroid gland.

That the thyroid function is intimately associated with metabolism is indicated by the fact that the thyroid activity is greatest in early life; after the age of thirty (30), when growth ceases and retrograde changes begin, atrophy begins also in the thyroid. The effects, too, of removal are much more marked in early life.

The cachexia produced by removal of the gland may be divided into three stages:

- 1, Neurotic, with tetanic spasms and following paralysis;
- 2, Myxœdema;
- 3, Cretinism.

Diseases of the Thyroid.—A study of the subject of goitre, or struma, as it is called, would seem to cover all diseases to which the gland is liable, as malignant new growths are included in the usual classification as struma maligna.

Inflammation occurring in a normal gland is known as thy-

roiditis; when occurring in goitrous gland, strumitis. Both forms are alike in their course, presenting, in addition to the usual clinical symptoms of inflammation in a gland, those due to compression of the trachea.

E. Tavel, from a number of bacteriological examinations, arrived at the conclusion that thyroiditis and strumitis are caused by hæmatogenic infection; exceptionally it is impossible to demonstrate a primary infection. It is, then, due to resorption infection from an unknown portion of the outer or inner surface of the body. In most cases a primary infection is demonstrable. It is then a metastatic infection. Cases occur frequently after typhoid and other infectious diseases. Tubercular infection is rare, but a number of cases have been reported, and are usually of the miliary type.

Struma Syphilitica.—From a careful study of the history of a large number of cases, Engel Reiman found that in the early period of syphilis one-half the cases showed enlargement of the thyroid. The swelling in these cases was soft, not causing any symptoms. Late enlargements in syphilis are very rare, only nine cases having been reported. One case reported by Koehler led to myxœdema. A case reported by Clarke led to Basedow's disease. Owing to the rarity of these cases, and the liability of confusing them with struma maligna, a full report of a case may be of interest.

Mr. K., aged 27 years. History of syphilis several years previously. Had had goitre from childhood. Recently had had several attacks of dyspnœa. Status presens. Man of powerful build, cyanotic, stridor even at rest. No difficulty in swallowing. Fist-sized goitre on right side covered with normal skin, tumor remarkably firm in consistence, almost immovable, partly retrosternal, pushing trachea to one side. Insignificant sensitiveness to pressure. Diagnosis, struma maligna. Attempt was made to remove growth, but so many and so firm were the adhesions as to render removal impossible. Tracheotomy was done to relieve impending suffocation, and a small piece of the tumor excised for examination. Microscopic section showed thyroid composed of sclerosed connective tissue, with marked round-celled infiltration around the vessels, thickening of the intima, and round-celled infiltration of the adventitia, with proliferation of endothelium in capillary vessels.

Active treatment with iodides for three weeks caused entire disappearance of the tumor.

Tuberculosis.—The early view that tubercular inflammation of the thyroid was a rare affection probably arose from the failure to examine the thyroid in tubercular cases, as later authorities agree that it is a common affection, usually of the miliary type.

Echinococcus.—*Echinococcus* is amongst the very rare affections of the thyroid. A. Henle, after an exhaustive examination of the literature of the subject, finding but eighteen (18) cases certain; three (3) uncertain. It presents in its general features the same appearance as other cysts of the thyroid. Section shows the characteristic scolices. Of the gland substance, but little remains, except along the borders of the cysts.

Carcinoma.—Carcinoma of the thyroid is comparatively rare, but is the most frequent of the malignant growths of the thyroid. It presents itself either as an epithelioma or a cylindrical-celled carcinoma.

Recently it has been suggested that there is a probability that in intrathoracic carcinoma it may be found that the primary seat of the growth has been the thyroid.

Sarcoma.—Sarcoma presents itself either in the form of small, round or spindle-celled growth. Pick reports an osteosarcoma with metastatic growth in lung, with formation of bone.

Goitre.—Probably more has been written regarding the etiology of goitre than upon any one subject in medicine. Goitre may be epidemic, endemic or sporadic. The constitution of the drinking-water has long held a foremost place in the minds of the profession as a causative factor in the two first-named varieties. Occurring sporadically, it is usually originally of the vascular type, and is probably simply an aggravation of the normal enlargement occurring during pregnancy, and from causes interfering with return circulation from the thyroid in certain occupations. Later, in consequence of continued congestion, there may be hyperplasia and subsequent degeneration.

Occurring epidemically and endemically, while the results of bacteriologic study have not given conclusive demonstration of

the fact, yet they point undeniably in the direction of a parasitic origin of this class of cases. A predisposing cause is suggested by Kocher to lie in the fact that, amongst the people particularly subject to goitre formation, foods poor in phosphorus are largely used. This suggestion seems a plausible one in view of the fact, which will be referred to later, that the internal administration of phosphorus has a marked curative effect upon goitre.

Varieties.—Goitre may be either acute or chronic, congenital or acquired. Acute forms are usually of the vascular type. Chronic goitre may be:

1. A vascular form which consists simply in dilatation of the vessels of the gland.
2. Diffuse—a general hyperplasia of the parenchyma of the thyroid, with very little formation of colloid.
3. Nodal—in which hyperplasia takes place in individual lobules, with normal tissue lying between.
4. Colloid—in which, with increased development of cells and vessels, there is built up an anastomosing arrangement of acini filled with colloid.
5. Cystic—in which larger and smaller cysts are formed by retention or degeneration.
6. Sclerotic—in which there is an increase of the connective tissue, with sometimes a formation of cysts by hyalin degeneration of the stroma. In reality, all forms of goitre, with the exception of the vascular, are simply due to varying conditions of growth, combined with differences in secretory activity and subsequent degeneration, and may be regarded as developing from the first or diffuse form.

7. Exophthalmic goitre.

I have included exophthalmic goitre amongst the other varieties of goitre, and I believe properly; for whatever underlying cause there may be for the perverted action of the gland, the symptoms themselves are only referable to disordered action of the thyroid—hyperthyreosis, as it is called. The symptoms of exophthalmic goitre and those produced by overdoses of thyroid extract are identical—tachycardia, emaciation, trembling anxiety, with exophthalmus. In all these cases there is found a hyperplasia of the gland, with increased secretion; later, changes in the character of the secretion; and, still

later, degenerative change to such degree that cases have been reported of exophthalmic goitre eventuating in myx-œdema.

Pathology.—In diffuse goitre the cells of the acini proliferate through direct division (mitosis has never been observed), forming solid processes, which push outward into the interstitial tissue, forming new nodules of gland tissue, resembling the foetal arrangement before the development of acini. Irritation of connective tissue leads to hyperplasia, thus closing in the nodules and forming new lobules. The diffuse form then consists in a homogeneous proliferation of all the lobules of the gland. The nodal form arises through the proliferation being confined to particular lobules of the gland.

Acini are formed in cords as follows: There appear, first, a clear space between the cells about the size of an epithelioid cell, produced by the secretion from the colloid-forming cells. By a continuation of the secretion and accumulation within the acini the colloid form arises.

The cystic form arises either by retention, or more usually by degeneration, usually described as a hyalin degeneration, but, from its staining peculiarities, more probably a colloid degeneration of the stroma and vessels.

The forms are not separate and distinct; frequently, in sections from the same tumor, portions of the section may show diffuse hyperplasia, resembling adenoma; colloid formation in other portions; and in still other places there may be colloid degeneration of the stroma and vessels, forming cysts.

The capillaries are abnormally wider; walls thin. Acini frequently, instead of being lined by a single layer of cells, may have three or four layers. The acini anastomose are irregular in shape and size. In the normal gland the acini are distinct, and do not intercommunicate.

Intratracheal Goitre.—On account of the close attachment of the thyroid to the trachea, the trachea itself is invaded by processes of the gland, which may take on goitrous enlargement. A number of cases of intratracheal goitre have been reported. In view of the fact that it was impossible to find a perforation of the tracheal wall in these cases, it was supposed that enlargement took place in aberrant remnants of the thyroid. It has been shown, however, that they are due to a pushing of pro-

cesses of the gland between the tracheal rings, and to be connected with the thyroid itself.

Intrathoracic Goitre.—Out of 1000 cases of goitre, Kocher reports 22 cases of intrathoracic goitre. He lays stress upon the following diagnostic points:

1. The patients suffer with unusually severe dyspnœa, with relatively small goitre in the neck.

2. The trachea is pushed to one side much more than can be accounted for by the tumor in the neck. Indeed, it can happen that the trachea is displaced towards the side of the greatest increase of the thyroid in the neck.

3. The neck-tumor is not sharply defined inferiorly.

4. It is impossible to either lift the neck part of the tumor or push it deeper, and trachea and larynx are less easily elevated.

5. Pressure symptoms on the large veins of the neck appear without sufficient ground in the appearance of the neck-tumor. The veins of the neck fill themselves from below when emptied by pressure. The veins of the arms are not emptied by raising the arms. In well-defined cases, headache, vertigo, roaring of the ears, nose-bleed, enfeeblement of memory point to stasis in veins of the brain.

6. Thus arises, frequently, paresis of the recurrent laryngeal nerve.

7. Dullness on percussion beneath manubrium.

8. Roentgen rays are of invaluable aid in making diagnosis; not only reveal presence and extent of tumor, but, what is of much more interest to the patient, show its mobility and the consequent possibility of its removal.

Kocher points out that persistent obstinate asthmatic attacks due to tracheal stenosis resisting treatment, are cases of goitre heart and goitre lung.

Treatment—Internal Treatment.—Iodine in some form or other has been and still is the leading remedy. Kocher points out its danger to lie in the development of symptoms of chronic iodism, excitement, sleeplessness, palpitation of the heart, with quick, irregular pulse and attacks of anxiety. When fully developed the nature of the case cannot be overlooked, but single symptoms or groups of symptoms may pass unrecognized.

Thyroidin or thyroid extract are effective, but lead to development of same symptoms.

Phosphorus was first suggested as a remedy by Traczewsky. Its effect is marked in diffuse and vascular forms of goitre, but not so marked, though of some value, in goitre with degenerative changes.

It is also of decided value in Basedow's disease.

In those cases not benefited by internal treatment on account of advanced tissue-changes and in malignant new growths, removal is indicated, preferably intracapsular enucleation, in order to avoid removal of parathyroids, as, by their subsequent development, the necessity of prolonged thyroid feeding is obviated.

It will probably be of interest, in this connection, to give a brief *résumé* of the report of Kocher's second thousand cases of excision of the thyroid. Kocher makes a symmetrically bow-shaped incision across tumor, afterward a median cut between the muscles which only in the severest cases are severed; ligates, as far as possible, the veins which trespass on surface of gland, afterward, the two chief branches of the superior and inferior thyroid arteries, luxates the goitre out of its surroundings, divides the isthmus, and in favorable cases ablates the organ. In dividing the isthmus in order to avoid mass ligatures, Kocher uses a forceps working on the principle of the modern angiotribe. His results are as follows: 27 malignant cases, 6 deaths; 20 strumatic cases, 2 deaths; 24 exophthalmic goitre, 2 deaths; 929 goitre, 4 deaths; mortality, 4 per cent. The causes of death in the 929 cases were as follows: 1, chloroform collapse; 2, cachexia thyreopriva; 3, sublimate poison; 4, pneumonia, four weeks after operation.

Aseptic technique is followed; silk ligatures are preferred, only using catgut when purulent inflammation has taken place.

Kocher regards antiseptics as peculiarly dangerous in exophthalmic goitre and heart cases, advises thyroid feeding for two days before removal, particularly when degenerative changes have taken place, and symptoms of cachexia thyreopriva are present. Tetanic symptoms leading to fatal issue have been reported, following immediately on recovery from anæsthetic.

He avoids general anæsthesia, using cocaine, with consequent absence of post-operative vomiting, so that danger of infection and secondary hæmorrhage, with formation of hæmatoma, is avoided.

In removal of intrathoracic growths, danger lies in hæmorrhage. In order, as far as possible, to eliminate this danger, all vessels that can be reached from above are ligated with double ligatures. Isthmus is divided. The neck-tumor isolated from the intrathoracic. After this, says Kocher, one is prepared to deliver the tumor—a real delivery, only to be accomplished with goitre forceps and goitre curette. The tumor being safely delivered, immediately the arteries are caught, ligated and cut. Sometimes, in spite of caution, the vessels are torn across; then compression against the sternum or first rib must be resorted to, until it is possible to see where bleeding comes from. It is impossible to tampon as the hæmorrhage is imperfectly checked, the mediastinum fills with blood and leads to suffocation. The greatest difficulties are encountered when the tumor is too large to be drawn through the opening of the thorax. It can only be removed by boring the finger into the capsule, breaking down soft parts within the capsule, opening cysts, sometimes an abscess, and by means of a specially designed curette removing tumor piecemeal.

It may be of interest to refer just here to a rather humorous contribution to the literature of the subject. After a careful and thoughtful consideration of the facts regarding the development, histology and pathology of the thyroid, Kock, a German writer, comes to the conclusion that goitre is a result of a thickening of the colloid secretion of the gland, so that it cannot escape from the acini, with formation of retention cysts and consequent general enlargement of the gland, and that a proper treatment should simply be directed to the thinning of the secretion. He therefore advises the daily injection of 10 c.c. of a 1 per cent. solution of carbolic acid in distilled water, claiming in this way to have cured numerous cases.

I have attempted in the foregoing simply to present, in as concise a form as possible, the present views upon the thyroid. That an ultimate solution of many vexed questions has been reached, cannot be claimed. Distinct advances have been made, notably in treatment, and light promises very soon to be shed upon the etiology of goitre. Such operative work as has been done by Kocher must lead to notable results in determining more exactly the functions of the gland.

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THE MODERN TREATMENT OF PULMONARY TUBERCULOSIS.

BY F. MORTIMER LAWRENCE, A.M., M.D., PHILADELPHIA.

(Read before the Homœopathic Practitioners' Association of Reading, Pa., July 30, 1902.)

IN one sense, at least, pulmonary tuberculosis is incurable. In saying this I refer to its most characteristic lesion, the tubercle, which differs from similar lesions, such, for instance, as the syphilitic gummata, in that it never undergoes resolution. So far as we know, the tubercular lesion, once established, persists until death, and it is found *post-mortem* in the lungs of a very large proportion of the human race.

From the pathological standpoint, therefore, pulmonary tuberculosis is never cured. Why, then, are clinicians the world over so optimistic concerning the possibility of recovery from consumption? The explanation is simple: because of the very autopsies that, in revealing the widespread existence of the disease, have shown that Nature herself has provided a practical, if not absolute, cure. By walling in the tubercle, by placing

about it a network of fibres of connective tissue so fine that they form an impervious obstacle to its growth, Nature interposes a check that is effective not merely in a few, but in an absolute majority of cases.

In the absence of means whereby we can more directly antagonize and destroy the infective agent, the physician must be content with humbly imitating and aiding Nature's method. Recognizing the fact that this practical cure of tuberculosis depends upon a process of fibrosis, he must seek the best means of promoting this connective tissue hyperplasia. Let him consult the pathologist, and the latter will tell him that, outside of heredity itself, the one greatest factor in the production of fibrosis is the gouty diathesis. Let me impress this fact upon you, for I am convinced that our most formidable single weapon in the war upon established pulmonary tuberculosis is that *bête noire* of modern therapeutics, the uric acid diathesis. We cure our consumptives by making them gouty.

Modern though its application in the way of treatment, the knowledge of this antagonism between gout and tuberculosis is by no means new. If I am not mistaken, it has been vaguely recognized since the time of Hippocrates, and certainly has been well known in recent years. For example, Harris and Beale state that they have seen tuberculosis arrested by "an intercurrent attack" of gout. Sir Herman Weber, in a recent address before the British Congress on Tuberculosis, asserted that "gout was a most favorable complication," 18 out of 25 patients cured of tuberculosis having developed gout in some form. Sir Dyce Duckworth, in his work on "Gout," has not failed to recognize the immunity of gouty subjects to tuberculosis. He says that the older writers "laid much stress upon the presence of cretified masses in the lungs of such persons. They would now be regarded, not as evidence of any specific gouty element, but merely as indications of obsolete and healed tubercular lesions." He recognizes "an antagonistic influence of the gouty upon the tubercular habit, and agrees with those who find tubercular processes checked often for long periods and rendered obsolete in virtue of gouty predisposition."

It must be acknowledged, however, that thorough appreciation of the possible therapeutic significance of this antagonism between gout and tuberculosis has been reached only since

hyperalimentation began to win its victories in the treatment of consumption. Overeating, the ingestion of an excess of "rich," *i.e.*, proteid, food, has long been recognized as the one great controllable cause of gout and all the sclerotic changes that follow in its train. It was not without reason that our forefathers ranked gluttony as one of the seven cardinal sins. It might even be considered the greatest of the seven, as measured by physical harms resulting; for I believe that a century of war, pestilence and famine could scarcely equal the deadly work which overeating accomplishes yearly.

But this does not apply to the consumptive. He, the opposite of his gouty brother, is over-oxidized; his waste exceeds his repair; he lacks all that of which the other has too much. The very things we take from the latter we must give to the former, if we are to help him cope with his mortal enemy. To this extent I believe in the heredity of consumption: that just as in 60 per cent. of cases gout is born with a man, so in a large proportion of cases an opposite condition is the tuberculous victim's birthright, and this it is which renders him vulnerable to the infective agent of the "great white plague."

With this generalization by way of introduction, let me add that, while I regard hyperalimentation as the most important single item in our modern treatment of consumption, it is not the only one. Certain climates, fresh air whatever the climate, and medicines, all these have their essential place in our therapeutics; and in order that we may consider the details of treatment systematically, I will discuss the latter under the three heads of diet, climate, and medicines.

1. *Diet.*—The consumptive should eat all that a gouty patient should not. The bulk of his food should be of proteid character, and he must consume enough of it. From this arises our first trouble, for the average consumptive—whether it be cause or effect we cannot always say—is troubled with poor digestion. In consequence, he is apt to demur at even moderate quantities of food; and, in overcoming his repugnance to a full diet, the physician must prove himself not merely a scientist but a diplomat. In all but a few cases the consumptive can eat and can digest if he but acquire the habit; for eating is like some bad habits, in that the more one eats the more one wants to eat. Therefore, after first explaining clearly, and, if

necessary, with some emphasis, the absolute necessity that the patient shall eat if he is to get well, it is wise to start with moderation and increase by definite amounts. In this, as in other dietetic matters, it is essential that the medical attendant be explicit, and on that account it is well to start with the fundamental idea that for the average adult consumptive two pounds of lean meat and three eggs a day is not excessive. This is not all the patient can eat; it is what he must eat, together with as much more as he can. The meat, preferably beef, can be prepared in a variety of ways, but it should always be understood that it is to be cooked as little as is compatible with the patient's appetite. Rare beefsteaks, roast beef, scraped raw-beef sandwiches, Hamburg steaks, all these are good; and then, by way of occasional variety, the patient can take lamb and mutton and veal, if he likes them. The eggs should be taken raw, if possible. They may be mixed with a little whiskey or sherry, or they may be taken, especially at this season, in the form of egg lemonade. In many cases, however, I find it best to give them raw and unmixed. Let the patient suck the egg from the shell, in the fashion of his boyhood days; or have him break one egg at a time into a cup, without breaking the yolk, add a dash of salt and pepper, and swallow it down. It is amazing to find how quickly the patient becomes accustomed to this; even fussy, squeamish, neurotic women take their raw eggs without a murmur. As a rule, the eggs should be taken at the close of each meal, for then they interfere less with the appetite for the next one. I do not, as a rule, advise the use of egg-nogs or milk-punches, for I know of nothing of which even a healthy person, let alone a sick one, will tire so soon.

It is enough to begin, as I have said, with three eggs a day; but it is not enough to stop at that. It is the minimum, not the maximum, allowance. In the second week of treatment, if the eggs are taken well, I am apt to increase to two eggs three times a day; and thereafter to keep up the increase, week by week, until twelve, eighteen, or even, as in one case, twenty-four raw eggs are taken daily. The gain in flesh and strength under these circumstances is striking. It seems to me that the egg must differ intrinsically from other forms of food not only in its ability to nourish but to stimulate nutritional processes.

In advocating this heroic method of nourishing consumptives I am, be it understood, speaking of the cases purely tuberculous. When the patient's temperature passes the 104.4° mark—the dividing-line, as Koch pointed out, between pure tuberculosis and streptococcic infection—the secondary infection must be controlled first. Rest and a semi-liquid diet are often necessary for a time, and so is medication; only when the temperature is persistently, morning and evening, below 100° , should we begin or resume our excessive feeding.

I will not go into details concerning other foods; they are none of them forbidden, provided they do not disorder the stomach and do not lessen to the slightest extent the consumption of meat and eggs. Milk is preferable to other beverages for these patients. There is one other article of diet—I dare not say food, although I believe that within certain limitations it is one—that we must consider, and that is alcohol. Nothing has been more highly praised and nothing more bitterly condemned than the use of alcohol by the consumptive. Here, as in other questions, middle ground is safest. In many cases good whiskey or good brandy, taken in small quantity with meals, seems to stimulate the appetite and aid digestion. On the other hand, excessive use of alcoholics certainly disorders digestion and destroys the appetite for food. The persistent use of alcohol is certainly one of the causes of gout, and so we have definite warrant for its use by the consumptive; but, personally, I do not prescribe alcoholics for these patients unless my advice is asked, and then I specify definitely the quantity, a half an ounce or an ounce, to be taken with each meal.

You will notice that I have not mentioned cod-liver oil, or any of the thousand-and-one emulsions and other preparations of it. My objection to it is twofold: first, because it is apt to lessen the appetite for the more essential foods, even if it does not actually disorder digestion; and, in the second place, because I can see no evidence that any fatty substance, a mere heat-producer, hastens the process of fibrosis, which, we must remember, it is our object to induce. Cod-liver oil will, so long as digestion remains good, produce a certain increase in weight; but the latter is simply fat. The iodine and other halogens, and perhaps still other medicinal substances present in the oil,

may contribute to its value, but not enough, it seems to me, to overbalance the objections to its use. Certainly cod-liver oil, even in the days when it was generally used in the treatment of tuberculosis, did little to check the ravages of that disease.

2. *Fresh Air.*—It took us a great many years to discover that it is not any one particular variety of climate, but rather certain climates, which, through their moderate temperature and sunshine, tempt the patient into living out of doors, that do so much for consumptives. Indeed, some rather inferior climates, such as that of Nordrach, have not interfered with the success and fame of the sanatoria there situated. From this it is but a single logical step to the belief, fast gaining ground, that any air, even that of our great cities, can accomplish a great deal if it is properly utilized. You all know, as I do, the folly of advising the average patient to go to Colorado, or New Mexico, or Southern California. Though it cannot be questioned that these resorts possess climates which will work wonders in appropriate cases, provided proper food and surroundings can be secured, it is so rarely that our patients can take up residence there that I am going to disregard them this afternoon. Indeed, even though the change of residence were possible, I would not advise it unless I were certain that the patient could secure an abundance of appropriate food after he got there.

It is surprising that we have so few institutions for the sanatorium treatment of consumption here in the East. During the past few years I have had the misfortune, from time to time, to discover evidences of tuberculosis in the lungs of certain of our students. In each of these cases I have advised the victim, if his finances permitted, that he go to one of the great European sanatoria, such as Falkenstein or Nordrach, and, while recovering his health, study in detail the methods there in vogue. Then, on returning to this country, he would be in a position to establish a similar institution. Up to this time my suggestion has not borne fruit, but I look forward with confidence to the time when the mountains about Reading or beyond in the Pocono region will be dotted with such sanatoria.

Assuming, however, that a vast majority of our consumptive patients must be treated at home, we need feel no discouragement. We can accomplish almost as much as can the best-situated and most modern sanatorium if we can enforce one

rule: that the patient shall spend every one of the twenty-four hours in the open air. The daylight hours must be spent out of doors in clear weather, in an open room in stormy weather, and the apartment in which the patient sleeps must never be closed to the air. This does not mean exposure; the patient should be screened from draughts and dressed as warmly as the temperature requires. Thus guarded, patients in the Adirondack region spend whole days at rest out of doors in a temperature 40° below zero—and they get well.

In directing the open-air treatment, as in prescribing other procedures, the medical attendant must be specific in his advice. He must state clearly to the patient, not merely that he is to “live out of doors,” but that he is, at least until the progress of the disease is checked and his temperature is persistently normal or subnormal, to *rest* out of doors. If this precaution is not observed, the patient will construe the directions into taking long walks or rides, thus tiring himself out and using up the income derived from his diet instead of storing it up as fresh capital. On this account it is necessary for the physician to investigate the details of the patient's home. If he has a yard of fair size, let that be the site of his “cure.” In the country, a porch is sufficient; in the city, the roof of a back-building is sometimes convenient and perfectly suitable for the prolonged period of out-door rest which the patient is to undergo. In this situation a sofa or reclining-chair is placed—a steamer-chair covered with a mattress is best—and alongside of it a wind-break, a protective screen that can be shifted to break the force of the wind, no matter from what point of the compass it comes, is placed in position. In case the patient's means are very limited, a very simple contrivance can be made to answer the purpose: a big packing-box with one end knocked out, or a canvas stretched between two uprights, whose bases are sufficiently broad to prevent their being overthrown by the force of the wind, will answer very well. If the patient be more extravagant, he may purchase one of the big wicker-hoods now made for the purpose. This must be lined with cloth, to prevent the wind penetrating its interstices. Whatever the contrivance, within its shelter the patient must spend his days, reading, writing, or otherwise amusing himself as he will. At night let him be put to bed and well-cov-

ered, and, if necessary, place a screen between him and the window; but see to it that the window is kept open.

The effect of this method, particularly as evidenced by the control of fever, is remarkable. Even a high, septic temperature responds to it, as it rarely does to drugs, and often after the latter have completely failed.

3. *Medicines.*—The physician who, in these days, prescribes medicine for a consumptive patient without at the same time advising him as to the dietetic and other details to be observed, is guilty of malpractice. I say this, not because I question the value of drugs, but because I believe them to constitute but a part of rational therapeutics. We have had centuries of almost exclusive drug-giving, and yet how little has been accomplished by medicinal therapeutics alone. In fact, we have only to consider the countless remedies that from time to time have been recommended for consumption to realize how utter has been the failure of exclusive drug-giving. It is notable that out of the motley array of remedies that have thus been recommended, only those retain a shred of reputation which have an effect upon nutrition. By this I mean the remedies prescribed in the general treatment of tuberculosis, apart from those prescribed for certain symptomatic complications, such as cough, fever, hæmoptysis, etc. Creosote, for example, was originally prescribed because of its supposed germicidal effect, but now it is acknowledged to act simply by preventing intestinal fermentation and stimulating the appetite. The same thing is true of strychnine, the hypophosphites, and a host of other remedies. Even arsenic iodide, which seems to be the distinctive remedy of our school and a worthy rival of all the other medicines, probably owes its success to the same nutritional effect. A single exception is found in the use of urea internally. An English clinician, basing his therapeutics upon the supposed association of urea-formation with the gouty diathesis, has administered a synthetic preparation of that chemical in doses of from 10 to 60 grains three times a day. His own reports indicate decided success, but I know of no other recorded experience with the remedy.

The paramount indications for the administration of drugs are found, however, in the symptoms; and in order to discuss medicinal treatment from a strictly clinical standpoint, I will

take up briefly four of the most important symptoms with which we have to deal, viz., cough, fever, hæmoptysis and diarrhœa.

(a) *Cough*.—It must be remembered that coughs are of two kinds,—those necessary to clear the respiratory passages of secretion, and hence to be encouraged rather than suppressed, and those due simply to irritation, and hence proper objects of treatment. Those of the first class should be aided by the administration of such medicines as apomorphine, ipecac, antimony arsenite, antimony iodide and tartar emetic, and also by the use of inhalants. Whenever there is fairly free secretion, as evidenced by expectoration and moist *râles*, it is advisable to prescribe the use of a Goodno or a Yeo inhaler and the well-tried mixture of equal parts of alcohol, chloroform and beechwood creosote. Twenty drops of this suffice for twenty minutes' inhalation, and are then renewed; and, as a rule, the patient uses the inhaler for periods of one hour, three times daily. During the last few years an attempt has been made to use formalin by inhalation. It is very irritating to the eyes and nose, and on that account it is necessary to begin with a very few drops, mixed with alcohol and chloroform. The nose may first be sprayed with plain albolene to protect it, and the eyes soon become accustomed to the fumes, so that the proportion of formalin in the mixture can be steadily increased. This acts particularly well in cases of pulmonary gangrene or in phthisis with cavities, overcoming the foul odors.

The annoying cough of irritation without expectoration, the incessant cough that so often leads to gagging and vomiting, require very different treatment. Here we must obey the old maxim and seek the cause. In the past, many of these coughs could be attributed to the fact that the patients went from warm, ill-ventilated rooms to cold bed-rooms, where, naturally, they coughed all night; but the fresh-air treatment does away with that as a cause. Nowadays it is much more often due, in my experience, to naso-pharyngeal disease, and is surprisingly well-controlled by cleansing the nose and throat by means of an alkaline spray and then using a little mentholated oil. If there is a hypertrophic rhinitis, or a pharyngitis, or any other local disease, it must, of course, receive appropriate treatment. In a few cases the cough seems to be induced by too great ex-

ertion in preparing for bed, and the patient must be directed to undress slowly and rest between times. Occasionally, in a case which defies all these measures, a cup of hot milk relieves the irritation; and the latter is particularly effective in relieving the coughs that come on during the latter part of the night and disturb the morning hours.

But sometimes all these measures fail, and an opiate becomes necessary if the patient is to secure any rest. Under these circumstances, codein, gr. $\frac{1}{4}$, or heroin, gr. $\frac{1}{24}$, is effective.

(b) *Fever*.—A temperature below 100.4° is, as I have said, purely tubercular, and requires no symptomatic treatment. When it rises above that point, however, it signifies secondary infection, probably with the streptococcus, and is a serious omen if uncontrolled. In many cases rest and fresh air are sufficient in themselves, a semi-liquid diet being advisable for a time. If these prove insufficient, or while they are being tried, a number of medicines are indicated, notably baptisia, quinine, and quinine arsenite. Silicea also has some reputation in these cases. In obstinate cases the remedy recommended by Dr. Goodno, thymol, is very effective. It should be given in capsules containing two or three grains, and as an anti-periodic; *i.e.*, two or three of these capsules should be given in succession at short intervals during the period which precedes the daily onset of fever. A remedy of similar value is ichthyol, which may be given in capsules in divided doses up to sixty minims or more daily. It is necessary, however, to fairly saturate the patient with the drug, and too often the excessive dosage deranges the digestive system. Occasionally, in an otherwise uncontrollable case, good results follow the injection of antistreptococcic serum.

(c) *Hemoptysis*.—The worst feature of the average attack of blood-spitting is the panic into which it throws the patient and his friends. On that account it is essential that the patient be removed immediately to a quiet, cool room, placed in a semi-recumbent position, and assured that in itself the blood-spitting rarely leads to serious consequences. There is no great harm in the popular remedies, such as salt or ice, which are usually administered; but if the attack is protracted and threatening, it is better to administer some such indicated remedy as ipecac, hamamelis, geranium, or hydrastinine hydrochlorate. If this

does not control the hæmorrhage, it is well to fall back on supra-renal extract in doses of three grains every three or four hours. This remedy appears to have a very great value in the treatment of hæmorrhage, wherever its site. In cases of pulmonary hæmorrhage not otherwise controlled, and in which the loss of blood threatened to terminate life, I would not hesitate, were the necessary apparatus procurable, to resort to the method originally advocated by Murphy as a cure for phthisis itself, the injection of nitrogen gas into the pleural cavity, in order to compress the lung. Moreover, if the loss of blood has been great, much good may be done by the use of normal saline solution, as by enteroclysis, hypodermoclysis, or actual intravenous infusion.

(d) *Diarrhœa*.—I speak of diarrhœa last because it is a symptom generally supposed to be terminal in its time of occurrence, and to indicate tuberculous ulceration of the intestine. If this were always true I would not include it within the limited space of the present paper; but as a matter of fact I have found diarrhœa more often than not a result of mere indigestion. Nevertheless, indigestion is a very serious matter for a consumptive—I am inclined to think that the prognosis depends more on the condition of the digestive organs than that of the lungs themselves. If there is diarrhœa, it is imperative that search be made at once in the patient's dietary for the food that disagrees. At the same time, whichever of the symptomatic remedies seems indicated should be administered; and if that does not prove efficient, I would not hesitate to give an intestinal antiseptic, such as bismuth subgallate or bismuth betanaphtholate, in ten-grain doses after each meal. This is, however, a matter for individual judgment; I can only say that this treatment has worked well in my hands.

There is much more that I might say to you, many details that cannot even be mentioned, but it is not possible to discuss so broad a subject as the treatment of tuberculosis within the limits of anything less than a book. In many things which I have said your experience may lead you to disagree with me; but on one point I trust there may be no divergence of opinion, and that is, that the cure of the consumptive depends primarily upon the proper use of food and fresh air.

ALBUMINURIA.

BY FRITZ C. ASKENSTEDT, M.D., LOUISVILLE, KY.

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THE clinical significance of albuminuria, varying, as it does, within very wide limits, must necessarily be studied in connection with associated symptoms. No more does every case of albuminuria mean Bright's disease than every cough consumption; for, although it constitutes an important symptom, directing attention to the kidneys as a possible seat of lesion, as a cough would to the lungs, its more frequent occurrence without structural changes in those organs affords it a broader clinical interpretation. By some it is claimed that albuminuria at times is a physiological process, since it is often a transitory result of a diet rich in proteids, and can be found in more than 20 per cent. of moderately healthy young men who never develop nephritis.

Undoubtedly, a large number of cases of albuminuria seem merely functional in nature, arising from such ordinary influences as a cold bath, physical or mental exercise, disappearing after rest in bed (cyclic albuminuria), recovery following after some months or years, in the vast majority of cases; but since casts are occasionally found in such urine, and the subjects are almost always anæmic or neurotic young men, it is quite likely that all these cases have a remote pathological basis. Also in various nervous affections, such as migraine, traumatic injuries to the head, delirium tremens, apoplexy, epilepsy, tetanus, exophthalmic goitre and intestinal colic, albuminuria is frequently present without anatomical changes in the kidneys.

Probably a slight change in the renal epithelium, as cloudy swelling, accounts for the presence of a small amount of albumin in the urine during the fastigium of fevers with high temperature, disappearing with the decline of the fever. In these cases no casts, except possibly a few hyaline, are present in the urine, which is reduced in quantity; the sp. gr. is high, the absolute as well as relative excretion of urea and uric acid is

increased, while the chlorides are diminished. In purpura, scurvy, leucocythæmia, pernicious anæmia, icterus, syphilis, or poisonings with arsenic, phosphorus, mercurius iodine, antimony, lead, turpentine, cantharides, carbolic acid, nitre, mustard, salicylic acid, alcohol, ether, chloroform, etc., it is a frequent result of the irritation produced directly upon the renal tissues.

Venous hyperæmia of the kidneys, as from organic heart-disease, from impeded pulmonary circulation overtaxing the right ventricle with consequent engorgement of the systemic veins, from pressure upon the renal veins by a gravid uterus or by tumors, may give rise to an albuminuria, generally associated with a diminished secretion of urine, which is of high sp. gr., rich in urates and containing a few hyaline and, perhaps, granular casts, and a relatively large amount of urea, although its total elimination may be slightly deficient.

During the later months of pregnancy a small amount of albumin may appear in the urine, with a normal excretion of urea and without casts, save a few of the hyaline variety. This albuminuria often intermits, and usually ceases within a few days after parturition; but frequent analyses should be made in such cases, lest a true nephritis develop. If to the albuminuria severe frontal headaches, disturbances of vision and gastric derangements are added, especially in the first pregnancy, eclampsia may be expected. Albuminuria in the first half of the period of gestation is likely to culminate in a parenchymatous nephritis, and to recur in subsequent pregnancies. The seriousness of these cases is often underestimated, for the percentage of albumin is usually low, the casts few, and œdema more often absent, until a sudden increase of albumin and urea in the urine herald a fatal issue. In albuminuria of pregnancy the serum-globulin, which in ordinary albuminurias is present in but small quantity, is much increased, and may ever exceed the serum-albumin in a relative estimate. A pre-existing chronic nephritis frequently will, under the influence of gestation, develop symptoms of acute nephritis, running a rapidly fatal course.

In acute nephritis the percentage of albumin is large, though subject to fluctuations, and often small at first. The urine is diminished in quantity, sometimes suppressed; the reaction is

acid, sp. gr. is high in the beginning—1020 to 1035; later may be as low as 1015, or even 1010; the total amount of urea is much reduced. The sediment, which is abundant, consists of urates, leucocytes, blood, renal epithelium, and various casts, as hyaline, granular, epithelial, and often blood-casts. When the decrease of the urine is not so marked, and fatty casts and epithelial cells undergoing fatty degeneration occur, together with red corpuscles and blood-casts, in fresh urine, we may suspect an acute exacerbation of a chronic nephritis.

In chronic parenchymatous nephritis the albumin is less than in the acute form, yet more profuse than in interstitial nephritis. The twenty-four hours urine is generally reduced in quantity—the day urine may be less than that secreted during the night—its sp. gr. is low. The elimination of urea is deficient, except during absorption of dropsical effusions, when it may reach the normal. Urates, granular *débris*, leucocytes, fatty granular cells, and narrow or broad hyaline, epithelial and *fatty* casts are found in the more or less abundant milky-looking sediment. When secondary connective tissue hyperplasia takes place, the urine becomes more profuse, resembling that of chronic interstitial nephritis, except that the albumin and sediment remain abundant, and a greater variety of casts is observed.

In the last-mentioned form of nephritis the urine is increased in amount, although on occasional days it may prove subnormal; its color pale, turning hazy after twenty-four hours; sp. gr. 1005 to 1015; the excretion of urea and *phosphoric acid* are both relatively and absolutely deficient; the albumin is scant or absent, and the casts, which are hyaline, are few in number. In a later stage, when the heart fails to maintain the high arterial tension, the quality of the urine runs below the normal, and the albumin and casts increase.

As a suspicious symptom of diabetes mellitus in its prodromic stage, Dr. Clifford Mitchell mentions in his work on "Renal Therapeutics" the voiding of urine containing a small amount of albumin, and perhaps a few casts, by a patient who has become obese, even if no sugar be found. In view of this statement, which I am not aware of having been made by anyone else, the following case may be of interest: Mrs. R., æt 62, cumbered with obesity and mentally much depressed, noticed

a thick, cloudy sediment in her urine, and a sample was sent me Nov. 26, 1897. It revealed a moderate amount of albumin and a sediment made up of red and white blood-cells; but no casts were found, while all solids were of full amount. The patient apparently improving, no further analysis was made before May 7, 1899, when a twenty-fours' secretion, measuring 5 pints, was examined. The sp. gr. was 1025; urea excreted, 0.012 gm. to c.c., or total, 438 grs; no albumin or casts, but 3.75 per cent. of sugar, amounting to 1373 grs. in twenty-four hours, was excreted. June 2, 1899, she passed 2216 grs. of sugar; no albumin. December 11th, of the same year, the sugar was reduced to 403 grs., while a small amount of albumin appeared and urea rose to 530 grs; quantity of urine, 66 oz. December 15th the quantity of urine was only 3 pints; sp. gr. 1021, urea 511 grs., excess of indican; sugar absent, a trace of albumin continuing; a small sediment contained leucocytes, but no casts found. May 14, 1900, there was present a trace of both albumin and sugar, but the patient seemed to be improving in general health. February 14, 1901, her urine was again analyzed and found normal, and the patient had apparently fully recovered.

Cases of diabetes when albuminuria alternates with glycosuria are occasionally observed. A sample of urine sent me by Dr. T. E. Peck, of Augusta, Ky., showed a sp. gr. of 1009; neutral reaction, light yellow color, urea 0.015 gm. to c.c., other solids approximately normal; no sugar, but a trace of albumin and a sediment of white cells, crystals of triple phosphates, uric acid and oxalate of lime appeared, but no casts were detected. In reply to my report, the Doctor stated that his patient had been diagnosed by another physician as a case of diabetes mellitus. A second sample, taken from twenty-four hours' urine, measuring 4 pints, was received fifteen days later, which proved to contain 2 per cent. of sugar, no diacetic acid, and not a trace of albumin. The occurrence of albuminuria, with various casts—an actual parenchymatous nephritis—associated with glycosuria in the last stage of diabetes mellitus, is not uncommon.

Albuminuria occurs constantly in amyloid degeneration of the kidneys, which frequently complicates chronic nephritis. In a typical case the urine, which is always loaded with albu-

min and serum-globulin, is at first increased in quantity, but is usually below normal in the advanced stage. It is pale yellow in color, of low sp. gr., 1010 to 1015, and contains a scant sediment of white cells, hyaline, granular and waxy casts, the latter giving the characteristic brown stain with iodine. The excretion of urea is but slightly diminished, and uræmia does not occur in uncomplicated cases.

Finally, it should be remembered that an admixture of albuminous substances, as blood, pus or lymph, with the urine, after it has passed from the kidneys, results in a spurious albuminuria. Simple or gonorrhœal inflammations of the pelvis, ureters, bladder or urethra often give rise to this condition, which might be suspected from the presence of nucleo-albumin, whose chemical reactions are almost identical with those of mucin. The presence of calculi in the pelvis or ureter usually causes an appearance of albumin in the urine, with or without red blood-cells. In men, semen in the urethra; in women, leukorrhœal discharge, menstrual blood or semen in the vagina may render the urine albuminous.

From the above brief summary of the occurrence of albumin in the urine, it will be seen that albuminuria depends upon a large number of heterogeneous conditions not recognizable by a urinary analysis without a careful consideration of the general symptomatology of the patient, and that, consequently, the therapeutics of this symptom must be as varied as the nature of the cause.

SOMETHING TO THINK ABOUT.—The great weakness of the general medicine of to-day is that, so far as it is more than blind empiricism, it is an applied science rather than an art. It shifts from heroism to expectancy, and from spoliation to stimulation, with the prevailing conceptions of the day as to life and disease. Maladies are studied with the eye of the naturalist rather than of the artist; and the student is turned out thoroughly equipped for their diagnosis, but helpless in their treatment. Hence the nihilism of so much of our modern teaching. Hence the miserable halfpenny-worth of therapeutic bread to the gallons of scientific sack offered at so many of our society meetings. "The physician's high and sole mission is to restore the sick to health."

Let us then recognize Medicine as the art of healing, and cultivate it accordingly. We have taken this paragraph from the late Dr. Hughes' work upon "The Principles and Practice of Homœopathy." Those who have not, as yet, read this book, have a treat before them. It is one of the most delightfully written books we have ever perused, and it is chock-full of precious truth.

EDITORIAL.

VISIONS.

"YOUR old men shall dream dreams, and your young men shall see visions," quoth we, as we perused with pleasurable excitement "The Vienna of America," in the August number of the *Medical Era*. The vision gradually unfolded itself before our mental eye in all its bewildering enchantment. Chicago, already recognized as the Vienna of America by reason of the number of students to be found there, is "to become and to remain, not only numerically, but in all respects, the greatest medical centre not only in America, but in the world."

Gradually the cumuli clouds of roseate hue and immense proportions conjured up by this statement took form and shape, and, with more than the ordinary precision of prophecy, the picture of the future of this new Vienna was painted, by the hand of the hopeful prophet, before our enraptured eyes.

We saw before us the University, with its affiliated colleges, "supported by endowment," and "paying its professors and instructors adequate and liberal salaries." We saw rising before us the one great college devoted exclusively to the teaching of surgery, from 9 A.M. to 5 P.M. every day in the year, by a teaching force "of distinguished men, homœopaths and allopaths, drawn together from Chicago" and the rest of the world. We heard a similar mixed corps of distinguished specialists teaching from early morn to dewy eve in a college devoted to the skin, venereal and genito-urinary diseases, while similar specialized colleges, with mixed bodies of instructors, offered all that was worth consideration in obstetrics and gynæcology. Emerging from the rosy cloud, beside these soon stood before us the Chicago Medical College, devoted exclusively to the teaching of "general medicine" and "all that pertains to the domain of the practice of medicine;" while not far off, dazzling the imagination by the strange beauty of its composite structure, we

beheld the college in which "homœopathic materia medica was taught" and "homœopathic therapeutics didactically taught and clinically applied." Here, too, we found the whole field of "general medicine" covered by "competent teachers and skilled clinicians."

With the eye of faith and with bated breath we watched the procession of numberless students as they made their way through the successive halls of learning, emerging therefrom at last as "the best-equipped physicians in the world."

As this fairy vision floated before our enraptured gaze, there rose into consciousness, on the wings of long-neglected memories, the strain of a students' refrain, "*Es giebt nur ein Wien*" ("There is only one Vienna"), and with it other visions of tobacco incense and malted libations; for, be it known, there is nothing more infectious than this dreaming of dreams and seeing of visions. Witness the gatherings of the "drummers" in hotel or railway coach; the conferences of countrymen in the store at the country cross-roads; the meeting of noted fishermen and sportsmen, *et id omne genus*. With the democratic tendency of the times to strip off all adventitious and unnecessary adornment, even of speech, we call such illustrations of the capability to dream dreams and see visions, with almost brutal frankness, "swapping yarns."

Call it what you will, no one is safe from its influence; the *bacillus imaginationis ventosæ* is almost sure to get in its work in spite of every precaution. Even while the glorious visions described above held us entranced, we experienced the first symptoms of infection. The scene began gradually to change, its features to become confused, and then, little by little, to resolve themselves into what proved to be but modifications of the original. The stately buildings and pillared domes melted away, and in their place we beheld a huge circus tent, whose sides and top were constantly flapping, moved by a wind seemingly not felt elsewhere. From the peak of the tent waved an enormous flag, blazoned with the words "Colossal Aggregation," while all around its sides were little tents, appearing almost microscopic by contrast, from which proceeded the most remarkable sounds of yelping and barking, interrupted at times by sounds of human voices. To enter the large tent we were obliged to pass through a crowd of "barkers," whose lusty but

monotonous shouts of "Greatest Numbers! Largest Area!" were evidently the source of the wind which so mysteriously caused the canvas of the tent to flap and sway.

At a loss to discover the nature of the performance given within, we entered, and with wonder gazed on a scene which in many respects forcibly recalled the menageries of our early childhood days. Arranged around the circumference of the tent were vans of various sizes, shapes, and colorings. Most of them were larger than the vans usually met with in the traveling circus, and of more pretentious architecture, supported on wheels, massive in appearance, but which, on closer inspection, proved to be made of light wicker-work, with rubber tires, many of which showed signs of previous puncture. We noticed that the vans were all connected by a narrow passage running from one to another, so as to form a continuous course,—arranged, however, somewhat in the manner of a mouse-trap, which allows the captured animal to go forward or remain where it is, but not to retreat. The character of the animals occupying the vans in our vision shows how fantastically the action of the *bacillus i. v.* upon the nervous system manifests itself. The animals represented, indeed, species and genera with the general appearance of which we were tolerably familiar; but here we found them altered and modified in various strange and fantastic ways in the endeavor to produce some resemblance between the several occupants of each cage. We were entirely at a loss to understand the standard according to which the various animals had been originally selected to occupy a van in common. At one time we imagined that the proprietors of the circus had been governed in their selection by similarity in the noises made, similarity in loudness, or in persistence, or in unintelligibility. Again, we thought it might have been a superficial resemblance in the length of their tails, or of the hair covering their heads or bodies, or in the markings of their bodies, or in the capacity of their stomachs, or, in short, in various other natural traits. Our efforts to solve the question were in vain; we could fix upon no one feature which could explain all cases. One thing, however, was certainly evident, and that was that the resemblance which was the original cause of the selection had been developed as much as possible by training, feeding, and even by mutilations, but that, in spite

of all efforts, the natural instincts of the animals had not been entirely eradicated; for in the intervals of the performance arose the snarlings and barkings, roarings and howlings, usually heard in other menageries. These breaches of the peace were, however, readily quieted by threats from the keepers and an occasional extra feed. We learned, also, that the success in producing the superficial resemblance between animals of quite different kinds had been accomplished mainly by means of diet. All were fed upon the same food. All received a substantial meat diet, no matter what their previous habits might have been. Even those which, in their natural state, had barely sustained life on a meagre diet of nuts and barks, received their share of meat the same as the once proud lord of the forest, and, wonderful to relate, seemed to suffer no ill effects from the change. Indeed, far from becoming more savage and bloodthirsty in their habits, as vegetarians would have us believe should have been the effects of eating meat, they became less quarrelsome, and more amenable to treatment by the keepers and by their fellows in the same cage. The absence of all bad effects from this change of diet may also have been due, in a measure, to the giving at frequent intervals of a kind of cracker, resembling Uneeda biscuits in general appearance, but larger and fuller in contour. On examining some of these we found that they were filled only with air, but were very legibly marked with the words "Colossal Aggregation." The animals seemed to enjoy these windy dainties very much, although, from the great numbers which we saw lying around in front of the various cages, they must have been regarded by the keepers as a very cheap article of diet.

It would take us too long to describe the various antics of the animals and their peculiarities of appearance as presented to us in our vision. The performance, according to large posters exhibited all about the interior of the tent, was to illustrate the beneficial effects of civilization and liberality of thought, when rightly applied, upon even those animals hitherto supposed to be actuated only by the instinct of self-preservation; at the same time, by allowing those of the public who could be induced to do so to submit themselves to the refining influences of these tamed creatures, to prove that the sentiment of altruism can be roused to activity even among animals, when well fed.

The vision began to fade, but had not disappeared entirely before we were able to see some callow youths enter the first van, and pass, after certain manipulations over them by the various animals contained therein, to the second, and so on through the whole line, by means of the narrow communicating openings noticed at first. During their stay in a van the occupants surrounded them, and, with much jabbering and gesticulation, pulled and hauled at them, their ears and hair and arms and legs, seeking to fashion them in some degree to a resemblance of themselves. As no two were exactly alike, the difficulty, yea, impossibility, of this soon became evident to us, and we were anxious to see what the resulting products of these manipulations were like. Fortunately, just before the vision faded, one who had passed through the entire ordeal popped out on the sawdust of the ring through an immense hopper, and I examined it with as much care as the constantly vanishing picture allowed me. We saw an immense head surmounting a body swollen out of all proportion, we could not tell whether by wind or water, or by both, resting upon spindle-shanks, scarcely capable of making progress under the superimposed weight. We expected to find despair written upon the countenance of this mutilated being. Far from it; whatever may have been its inmost feelings, only satisfaction and self-complacency were displayed, for the misshapen body was ostentatiously enveloped in a coat of sheepskin, marked in gaudy colors "From the Colossal Aggregation." Then my vision was gone.

TO POINT A MORAL.

FIFTEEN years ago, when the agitation for State regulation of the practice of pharmacy had finally reached the stage of legislative enactment, two distinct bills were passed and sent to the Governor for his approval. The first bill created a Board of Examiners in homœopathic pharmacy, the second did as much for the ordinary druggists. Governor Beaver, then in the chair, was not averse to signing both bills; but he urged that, in the interest of simplicity, the two schools be combined in a single board. This request was finally acceded to by both

parties, and the Governor promptly appointed a homœopathic pharmacist as a member of the board. Unfortunately, however, it was deemed inadvisable, because of the danger of delay or even defeat for the project, to send the bills back to the Legislature for amendment; and so the continued recognition of the new school became a matter of pledged honor rather than specific legislative enactment. Nevertheless, every successor to Governor Beaver, Democrat or Republican, has respected that pledge until the present occupant came to the chair. Necessity knows no law, and in particular recognizes no unwritten one; and so, upon the expiration of the term of the homœopathic incumbent this year, he has proceeded to turn the position over to one of his political adherents, an old-school druggist.

Whether the Legislature will acquiesce in this betrayal of an honorably-given pledge by confirming the appointment remains to be seen. Whether it does or not, however, the present plight of homœopathic pharmacy in Pennsylvania should furnish an object-lesson to those invertebrate individuals who have urged, now and in the past, that we "trust to the honor" of those who hate us.

THE MEDICAL TREATMENT OF GALLSTONES.

THE invasion by the surgeon of the erstwhile realm of internal therapeutics has gone unchecked for several years; and even the internists themselves, becoming convinced of the efficacy of mechanical procedures in overcoming certain heretofore "incurable" conditions, have hastened to summon the operator to their aid. From the pelvis he has progressed steadily upward, claiming for his own the peritoneum and its inflammations, the intestinal tract and its perforative lesions, the liver, the gall-bladder and ducts, and, finally, even the diseased kidneys. As if this were not enough, only recently we have had the spectacle of an internal therapist, none other than Sir Lauder Brunton, calling upon the surgeons to devise means to overcome the obstruction of a mitral stenosis. It might almost seem that the next generation is to see the fulfilment of the prophecy that in the course of time there will be nothing but surgeons and nurses.

Perhaps it is time that a voice was raised in protest. There is always danger in the far swing of the pendulum. We acknowledge that, in some cases of portal obstruction due to hepatic cirrhosis, surgery has accomplished what medicine cannot hope to do. We may even look forward with complacency to the day when the victim of gout may gratify his appetite unchecked, happy in the consciousness that when his kidneys become unduly contracted the surgeon will kindly "decapsulate" them, and let their owner go on his way rejoicing. Whether, however, the prospect will appear so hopeful when statistics have accumulated, and it is possible to compare the ultimate results of surgical interference with the less showy ones of internal medication, is a serious question.

Keay, whose extremely readable book on "The Medical Treatment of Gallstones" has recently been issued, does not hesitate to throw down the gauntlet to the surgeon. Himself the victim of cholelithiasis, he has taken an intense personal interest in the pathology and therapeutics of that disease; and his conclusions, though scarcely apt to be accepted by a majority of his surgical *confrères*, are entitled to respect. He quotes Schröder, who found gallstones in 12.26 per cent. of 1150 autopsies, and Brockbank, who in 742 post-mortems found 6.6 per cent. of gallstones, and concludes that, "did every individual in whose gall-bladder or bile-ducts are gallstones suffer, in consequence, the agonies of biliary colic, peace on earth would be impossible, for every gathering in church, theatre or music-hall would be disturbed by the groans of the sufferers." That happily this is not the case is conclusive proof that only exceptionally does the presence of gallstones lead to serious symptoms. This is, of course, a well-attested fact. When the stones do not migrate or set up inflammation there is no need for interference; and on this account Keay contends that if, by medical means, the stones can be kept at rest and inflammation prevented, surgical intervention is not only unnecessary but mischievous. His own therapeutics are simple enough. Food, he asserts, is the most powerful stimulant of the flow of bile; and so he has little patience with dietetic restrictions, and prefers a full allowance of digestible food, together with a more than average supply of water, taken some hours after meals. Great benefit appears to be derived from

the constant use of the waters of Carlsbad or Contrexéville. Rational out-of-door exercise is commended; and this, with morphine or chloroform to palliate attacks of colic, appears to constitute his armamentarium.

These and similar medicinal and hygienic measures can, he asserts, show a vastly larger proportion of cures than does surgical interference. By accepting the authority of Kehr, who reckons that in Germany one out of every ten individuals, or, in all, 2,000,000 persons, have gallstones, and by applying the post-mortem statistics which indicate that in England, with twice the population of Germany, gallstones are half as prevalent, Keay is able to conclude that in England, also, 2,000,000 people are afflicted with cholelithiasis. Accepting Kehr's reckoning that only 1 in 20 ever suffer from biliary colic or other symptoms of the disease, there would be about 100,000 such sufferers. Of these, probably 2000 have actually been operated on during the past ten years, and, judging by the statistics of Mayo Robson and others, the results have not always been satisfactory. The surgeons speak of a mortality varying from 1 per cent. in the simplest cases to anywhere from 5 to 30 per cent. in those more complicated. But what of the 98,000 who have not undergone operation? Medical men in large practice state that, though they have attended many patients for gallstones, they have never certified to a death from that cause. Moreover, 1899, the year in which the largest number of deaths from gallstones was reported, showed only about 1 in 1200 deaths as due to that cause. Medical men in Carlsbad, to which many sufferers with aggravated cases resort, say that they seldom have a fatal case, and send few to the surgeon.

On the other hand, Naunyn's surgical statistics of 150 cases show, after excluding 11 deaths due to cancer, a mortality of 6.5 per cent. Certainly, says Keay, no lessened mortality seems to have accrued from operation, and he concludes that:

"1. The importance of diagnosis and treatment in the earliest stages of gallstones cannot be too fully realized, as complications may afterwards arise that will defy all treatment by physician or surgeon.

"2. We are further convinced that the records of gall-bladder surgery during the past ten years have clearly shown that the results anticipated have not been realized, and that, unless in

the most exceptional cases, the gall-bladder sufferer will derive more and lasting benefit from hygienic and medical treatment than from operation."

While statistics are always fallible, and Keay's are probably no less so than others, there is yet enough probability in his assertions to call for serious consideration; for his is probably the unspoken thought of careful internists the world over. Few physicians of wide experience can have failed to observe the complete and permanent disappearance of the symptoms of cholelithiasis under a wise hygienic and medicinal regimen; and probably fewer still would be willing to assert that, all in all, the disease proves fatal in even 1 per cent. of cases. Under these circumstances it seems evident that operative interference should be reserved for certain definite conditions which are of necessity incurable by other means. Unfortunately, however, these exact conditions are not agreed upon by surgeons, and there is constant danger in the *furor operandi* which appears to seize every tyro possessed of a knife when a new operation is proposed. For the present, it would seem wise that questions of surgical interference be left to the decision only of the most judicial, if not most conservative, of surgical diagnosticians. It is safe to assume that in such hands the patient would never be exposed unnecessarily to such dangers as are indicated by the statistics of Keay.

ENLARGED LYMPHATIC GLANDS AGAIN.—Some time ago we published in this department some remarks upon the treatment of enlarged cervical lymphatics by the internal administration of small doses of the "dark iodide of lime." Since that time we have had opportunity to confirm the writer's recommendation of this medicine. A girl, aged sixteen years, had a large bunch of enlarged glands upon the left side of her neck. She was evidently strumous, but presented no symptoms upon which an accurate selection of remedies could be made; unless, indeed, we considered a tendency toward softening at one point and much pain of a stabbing character, reliable indications. Surgeons whom she consulted ordered an immediate cleaning out of the mass. With some misgivings, we began the use of the iodide of lime—ten grains dissolved in four ounces of water, kept in a black bottle and given in teaspoonful doses of the solution every four to six hours. The mass of glands simply disappeared within a few weeks, with a marked improvement in the appearance, color and general health of the patient. It is not our intention to claim that internal medication, in such cases, is superior to the surgical treatment, nor even to offer it as a universal substitute. However, we are pleased to note the efficacy of this remedy in the case in question, and to confirm the observation made by the former writer.

GLEANINGS.

THE CURE OF TUBERCULOUS MENINGITIS BY CREOSOTE.—Since the introduction of lumbar puncture for diagnosis, cases of tuberculous meningitis have been observed which, contrary to the previously accepted belief, resulted in recovery. Thomalla (*Berl. Klin. Woch.*, June 16, 1902) reports a case of tuberculous meningitis in which recovery followed the use of creosote in liberal doses. The diagnosis was confirmed by Professors Gerhard and Von Michel. The patient was a male, aged 20, whose parents had died of tuberculosis and who had been cauterized for local tuberculous processes of the tonsils, tongue and neck. For several years the patient suffered from an incurable fistula *in ano*. During the progress of the case tubercles were found in the choroid of the left eye. From the beginning of the attack creosote was administered in increasing doses, until the daily quantity of four and a half grams, divided into three doses and given in capsules, was reached. In addition to the use of creosote, the treatment relied on in this case was chiefly the administration of potassium iodide and the painstaking nourishment of the patient.

Chaumier regards creosote of value in these cases only if given in doses of at least two grams daily, and only then if combined with outdoor treatment. Burlivieux recommends the injection of creosote in increasing doses, up to five grams. Thomalla places the limit at the point of toleration, and remarks that creosote is found in the blood-serum in proportion to the dose given. Not only the daily quantity, but the individual dose, should be as large as possible, inasmuch as the drug is very rapidly eliminated. The efficient working of the drug depends upon the saturation of diseased areas with this really powerful bactericide.—*Med. News*, Aug. 9, 1902.

F. Mortimer Lawrence, M.D.

GOUT IN THE UNITED STATES.—Fletcher (Baltimore), in a paper presented to the section in Practice of Medicine of the American Medical Association, reached the following conclusions:

1. Gout in the United States is undoubtedly more common than is generally supposed.

2. Out of 13,400 medical cases admitted to Dr. Osler's wards in the Johns Hopkins Hospital, during a period of thirteen years, there were 35 gout cases, or 0.24 per cent. of the total number of patients. For the same number of years, at St. Bartholomew's Hospital, there were 116 gout cases out of a total of 31,100 medical admissions, or 0.37 per cent. of the cases. Thus, among hospital patients, gout is only about one-third more frequent in London than in Baltimore. All the 36 cases were in white males. The largest number of cases occurred in the fifth decade.

3. The majority of cases appear to have earned, rather than inherited, their gout. Alcohol and lead seem to be the most potent predisposing factors.

3. Thirty-four of the 36 cases had reached the chronic stage before they came under observation. In 17 of the cases topi were present.

5. Among the most interesting complications may be mentioned 3 cases of gouty bursitis; 1 case of parotiditis; 1 of pericarditis; 1 of retrocedent gout, with symptoms simulating intestinal obstruction.

5. There was evidence of disease of the kidneys in a majority of cases. Albuminuria occurred in 27, and hyaline and granular casts in 23 instances.

7. Arterio-sclerosis was present in 23 cases, and a mitral systolic murmur in 5 cases.

8. Many gout cases are mistaken for rheumatism. Four of the cases were repeatedly diagnosticated as such on the early admissions, the appearance of the topi later revealing their true character.

9. The series illustrates the great importance of examining the ears and the vicinity of the joints for the presence of the topi in all cases of multiple arthritis.—*N. Y. Med. Jour.*, July 5, 1902.

F. Mortimer Lawrence, M.D.

A NEW FLUOROSCOPIC AND PERCUSSION SIGN OF PLEURITIC EFFUSION.—Greene (St. Paul) has noted that there is marked excursion of the heart-borders in cases of pleuritic effusion as viewed by the fluoroscope during deep respiration, and this observation he found to be easily confirmed by percussion. In connection with a preliminary report which embraces two cases, he makes the following statements:

1. In unilateral pleural effusion, the heart-border corresponding to the opposite side shows a marked change in position as between full inspiration and full expiration, when the patient is sitting or standing erect.

2. This is easily demonstrated by percussion, sustained by the evidence afforded by inspection and apex auscultation, and absolutely confirmed, if necessary, by the fluoroscope.

3. Such a range of excursion does not occur in the normal chest or in those conditions likely to be confounded with pleuritic exudation.

4. The technique consists simply in percussing the free cardiac border in full inspiration, and, again, in forced expiration with the patient in a standing or sitting posture, and noting the change in position. The border will be displaced *outward* by the *expiratory* movement.

5. Percussion of the upper border of flatness posteriorly shows a well-defined rise of the fluid in full expiration, coincident with the outward displacement of the heart.—*N. Y. Med. Jour.*, Aug. 9, 1902.

F. Mortimer Lawrence, M.D.

THE ADMINISTRATION OF WATER IN DISEASE.—Lydston (Chicago) sounds a warning note against the too indiscriminate use of water in large quantities. His contentions, briefly stated, are as follows:

1. While the ingestion of large quantities of water in various affections is often of great value, the treatment is sometimes extremely detrimental.

2. The nutritive value of the blood is often impaired by the relative hy-dremia produced by the ingestion of large quantities of water.

3. Disturbances of the circulatory and nervous systems are frequently produced by it. So-called weak heart, palpitation, nervous irritability, lassitude and exhaustion on slight exertion, are among the phenomena that may result.

4. Serious digestive disturbance, involving impairment of the secretion and

composition of the gastro-intestinal juices, and gastromotor insufficiency, may be produced by the ingestion of water in large quantities.

5. Œdema and anasarca, while often relieved by the free ingestion of water under favorable circumstances, are not infrequently enhanced by it.

6. Renal water habit may develop, by virtue of which the kidney becomes permanently sluggish, unless it receives its wonted stimulus of large quantities of water.

7. Acute and chronic inflammatory affections of the kidney are sometimes aggravated by giving water in excess, simply by overworking the renal organs.

8. Inflammatory affections of the lower portion of the genito-urinary tract are often deleteriously affected by excessive water-drinking, through the mechanical disturbance necessitated by the resultant frequent and copious micturition.—*Med. News*, Aug. 9, 1902.

F. Mortimer Lawrence, M.D.

A NEW REACTION FOR DIACETIC ACID.—E. Riegler (*Medecin. Blät.*, April 3, 1902), while working on the determination of sulphuric acid in urine, discovered a new test for diacetic acid. Fifteen cubic centimetres of urine are acidulated with from five to ten drops of concentrated sulphuric acid; when two or three cubic centimetres of an aqueous solution of iodic acid are added, an intense pink color will appear, which is not taken up by chloroform. Other substances that are liable to occur in urine were tested, but none gave the same reaction, which is still strong when the ferric chloride test fails.—*Med. News*, July 19, 1902.

F. Mortimer Lawrence, M.D.

SPLenic ANÆMIA AND ITS VARIETIES.—Osler (Baltimore), at the recent meeting of the Association of American Physicians, stated that he had seen many cases last for 12 years; one had lasted 20 years; and in more than half of his cases, the duration had been over 7 years. The spleen had been very large, and remained unchanged for a number of years. There was no enlargement of the lymph glands. The blood-changes were those of chloranæmia. There were hæmorrhages from kidney and stomach, and when we reflect that 40 per cent of the blood of the stomach is discharged in the splenic vein, we can understand the fullness of the veins at the cardiac end of the stomach. There was pigmentation of the skin, which was sometimes mottled. In the late stages there was reduction or enlargement of the liver. Jaundice sometimes occurred. To this group of cases has been given the name anæmia splenica. At the Johns Hopkins Hospital there had been operations in three cases. One operation was performed four years ago, and the patient is still living. In that case there were enlarged spleen, hæmorrhage, and marked pigmentation. The two other patients died.

The nature of the disease is unknown. Whether it is due to the spleen is as yet unsettled. The only point in favor of the spleen having something to do with it is that a certain number of patients have recovered after removal of the spleen. It is more probably a chronic malady of unknown etiology, in which the enlarged spleen is only a single expression. It is not so rare a malady as has been supposed, forty-two cases having been reported.—*N. Y. Med. Jour.*, Aug. 9, 1902.

F. Mortimer Lawrence, M.D.

THE INTERNAL USES OF CARBOLIC ACID.—Dr. S. Henry Dessau, in a paper read before the Medical Association of the Greater City of New York, said that it was natural that a feeling of incredulity and hesitation should exist in regard to the virtues of a remedy whose reputation is so closely associated with criminal poisonings, to say nothing of early prejudice founded upon false interpretations of its physiologic manifestations. His experience with the internal use of carbolic acid began in 1894. His reason for employing it was that it was an internal antiseptic. As pre-eminently the type of germicides, being evolved by nature in the physiologic processes of animal digestion, he believed that it should be accepted as a specific remedy against the disease action of a certain class of germs. Clinical results seem from his own observations to bear out this idea in a most gratifying manner. His experience with its effects has been chiefly in the treatment of catarrhal complaints involving the respiratory tract, and particularly in influenza among infants and children. His results from the use of carbolic acid have been better and quicker than from any other treatment. They have been especially satisfactory in those cases in which it has been almost impossible to keep the little patients in bed. The method of administration preferred is in the form of solutions of 1, 2, 3 and 5 per cent. of chemically pure carbolic acid. An infant under one year old receives a teaspoonful of the 1 per cent. solution, while a child of five years may get the same dose of a 5 per cent. solution, every two hours. Adults may take a tablespoonful of the 5 per cent. solution. A small amount of glycerin aids in preparing a more complete solution, and cinnamon-water is useful in disguising the pungency of the acid.

The author believes that carbolic acid is best indicated in those affections in which the disease germ is of a weak nature and manifests its pathological action principally upon the mucous membranes. He also believes that its field of usefulness will eventually prove broader than it is at present, and that such diseases as erysipelas, and even typhoid fever and pneumonia, will prove amenable to its effects. There is no valid reason why carbolic acid should not show as good results in pneumonia as creosote, and the advantage of the acid over the latter pharmaceutically, as an internal remedy, is that for children it makes a better solution, and has a less disagreeable odor. It has been found by him and others perfectly harmless and free from secondary effects when administered in the doses mentioned. The smoky color of the urine is now known to depend upon the elimination of the acid in a changed form, designated as the glycuronate of hydroquinone and pyrocatechin. The presence of albumin in the urine may or may not be due to an irritation of the kidneys by this substance, but it is a fact that no interference with the renal functions has ever been observed by him from the remedy in an experience now covering some four thousand cases. The only idiosyncrasy observed against its use has been that of vomiting.—*Med. News*, Aug. 9, 1902.

F. Mortimer Lawrence, M.D.

COFFEE AND BEER IN LITHEMIA.—Sajous (*Mthly. Cyclopedia of Practical Medicine*) summarizes the results obtained by Dr. A. E. Taylor in a series of observations made on himself with various diets and published in the *American Journal of the Medical Sciences* for August, 1899. These results are most striking and instructive. The output of urea, the normal end-product

of nitrogenous metabolism, was greatest during the period of normal mixed diet without coffee or beer—40.752 grams—with the exception of one other period, that when an extra heavy proteid diet was taken. It then reached 59.021 grams; but was distinctly less in the eighth period, when coffee was added without beer—39.225 grams. When both coffee and beer were added in the seventh period, the amount of urea was slightly more—39.935—but still less than under the normal diet without either beverage. Thus, coffee and beer markedly lessened the oxidation of the nitrogen of the food, and with the addition of coffee alone it was even worse.

But the two periods in which coffee or coffee and beer both were added to the normal mixed diet showed not only a very large increase of uric acid (worse with coffee alone than with both added), but also a most striking increase of the xanthin bases. These poisonous bodies—which have proved highly toxic to animals and are believed to be the real cause of lithæmic symptoms and the various other systemic derangements that have been usually attributed, especially by Haig, to uric acid—were thus in largest quantity when both coffee and beer were taken.

Reed (*International Med. Magazine*, April, 1902) is of the opinion that Dr. Taylor's observations confirm the chemical researches which show that the alkaloids of coffee and tea are closely related to the xanthins, and also bear out clinical experience to the effect that coffee and beer, however agreeable and refreshing as well as apparently safe in moderation for healthy persons, are injurious in lithæmic cases.—*Med. Times*, Aug., 1902.

F. Mortimer Lawrence, M.D.

THE EXAMINATION OF THE GASTRIC CONTENTS IN CHILDREN.—Louis Fischer has conducted a series of examinations of the gastric contents of children in a variety of conditions, from a study of which he is enabled to draw most instructive conclusions. The examination consisted in a search for free hydrochloric acid with Günzberg's reagent; the estimation of the total acidity by titration; search for lactic acid with Uffelmann's test, and the determination of the presence of propeptone, peptone, pepsin and rennet by the usual means. The mobility of the stomach was tested by means of salol, which does not absorb until it reaches the alkaline small intestine, and when this takes place salicylic acid is found in the urine.

Free hydrochloric acid was not present in very young children, especially in those cases fed exclusively on milk. This was equally true of breast-fed and bottle-fed babies. The hydrochloric acid that was secreted existed as a combination with the albumin, *i.e.*, an acid albuminate.

The following conclusions are drawn by the author:

In atrophic children and in subacute dyspeptic conditions HCl could not be found. Lactic and butyric acid was present. Sometimes acetic acid was found. There was acidity in all anæmic conditions, also in athrepsia infantum. The mobility was greatly reduced.

In very young infants, especially in healthy nurslings, there is an excess of lactic acid at the commencement of digestion after the sixth month, and until the end of the first year. Free hydrochloric acid can be found at the end of the digestive process in the same proportion as it is found in the adult. In healthy children over one year, we find free hydrochloric acid in one to one and a half hours after feeding.

At the beginning of the digestive process lactic acid predominates; at the end of digestion HCl predominates.

The gastric contents of children fed on raw milk, warm milk warmed to normal blood temperature, always showed a better state of digestion than did those fed on milk subjected to superheating. Constipation was also a result of feeding sterilized milk.

Exclusive feeding on sterilized milk produces systemic defects and subnormal tendencies to infection.—*Medical News*, July 5, 1902.

C. Sigmund Raue, M.D.

EMPHYEMA IN CHILDREN.—Cotton (Boston) has carefully studied 180 cases of empyema in children occurring in the Children's and Infants' Hospitals during the past two years. All the patients were under twelve years of age; 51 per cent. were under and 49 per cent. over five years. His general conclusions, which apply to children only, are as follows:

1. Empyema in children usually follows lobar pneumonia—after a varying interval.

2. The infection is usually with the pneumococcus.

3. Spontaneous cure, even when aided by tapping, is rare.

4. Operation should not be delayed, as time lost is strength lost, and the issue is largely one of nutrition.

5. The best form of operation is, in general, the subperiosteal resection of an inch of the eighth or ninth rib in the posterior axillary line, the evacuation of pus and fibrin masses, and tube drainage.

6. Irrigation at or after operation is not usually advisable.

7. The routine after-treatment, in fresh cases, should be tube-drainage, the tube being progressively shortened, and removed when the cavity is nearly healed.

8. When failure to heal seems to depend on failure of the lung to expand, treatment by valve or suction apparatus is indicated. This is especially of value in the more chronic cases.

9. The mortality is about one in seven; in smaller children it is much greater than in those over five years. The causes of mortality are, in the main, beyond our control.

10. The great majority of cases heal even when the healing is delayed for many months. Chronic empyema, in the strict sense, is rare in children.

11. The closure of the cavity depends mainly on nutrition and an adequate drainage.

12. Recurrences may occur from faulty drainage at any time, and they may occur years after apparently sound healing without obvious cause.

13. Deformity of the chest is usually temporary, and yields to treatment.

14. Long-continued discharge from the cavity is not infrequently followed by chest deformity and sclerosis of severe type, permanent and sometimes extremely severe.—*Medical News*, July 17, 1902.

C. Sigmund Raue, M.D.

THE EAR COMPLICATIONS OF MEASLES.—The ear complications of measles are usually light and progress to recovery, but a certain number leave serious defects. The physician should, therefore, always be on the alert, and watch for involvement of the ear when treating cases of measles. There is no doubt that the general catarrhal condition spreads to the mucous membranes of the

auditory apparatus, as also the exanthem. The toxæmia also affects the organs of hearing. When suppuration takes place, it is the result of a mixed infection with the streptococcus pyogenes, staphylococcus pyogenes and aureus, and the pneumococcus. The prognosis is worse when the streptococcus and pneumococcus are present.

Adenoid vegetations act as predisposing causes.

In infants the advent of otitis media is accompanied by a rise in temperature, usually 104° , and frequently convulsions. Rupture of the membrane and the free discharge of pus is followed by relief of symptoms. When the mastoid antrum becomes invaded there is a recurrence of fever; tenderness over the antrum, that is at the attachment of the auricle close to the superior wall of the canal, or the pain may be most pronounced over the mastoid tip. In infants, the pus often escapes through the Rivinian segment, having made its way along the superior wall of the canal; and there is a postauricular swelling, causing the ear to stand out prominently. Perforation may also take place on the internal surface of the mastoid, when a brawny swelling will extend along the sterno-cleido mastoid. If pus passes to the brain there is headache and drowsiness or violent delirium, convulsions, disordered speech, vomiting and pareses of various kinds.

In examining an infant's ear, the lobe should be pulled downward and outward and we should look upward. In children the canal is straight and the membrane is easily inspected.

The writer advises paying strict attention to the nose and throat during attacks of measles, and early incision of the drum membrane if needed or if in doubt. A general anæsthetic is required.

Under good illumination and antiseptic precautions the knife is passed through the bulging portion, or from the point behind or below the stapes to the lower border of the membrane close to its bony attachment.

Cleansing with a saturated solution of boric acid and lightly packing with gauze is the best after-treatment. Opiates are not to be recommended, as their use makes the symptoms. The local use of a watery solution of morphine, cocaine and atropine has never been satisfactory. Oils are to be condemned. Glycerine with 5 to 10 per cent. of carbolic acid, applied to the drum-head on cotton, often cures the pain. Frequent irrigation with hot water is also efficacious.—Herman Jarecky, *Medical Record*, July 19, 1902.

C. Sigmund Raue, M.D.

THE TREATMENT OF SUMMER DIARRHŒA.—*Pædiatrics* (July 15, 1902) considers the subject of the treatment of summer diarrhœa in infants editorially, and gives the following excellent directions for managing these cases:

Treatment may be summarized in these words: (1) diet, (2) quiet, (3) medicine. Diet is the most vital item in the list. In an ordinary case of summer diarrhœa only boiled water for 24 to 36 hours, until the passages have improved, should be given. When the parents need "doctoring," as well as the children, the baby may receive boiled barley-water (carefully strained, sweetened and salted) or rice-water. Oatmeal-water is less desirable from its unrecognized tendency to relax the intestinal muscle. Should the child remain unimproved for a longer period than 36 hours, of course nutriment must be given. Under these circumstances, albumin-water (with a drop or two of lemon juice) and barley-water are recommended. Sufficiently supplied,

this diet will run the case quite well for several weeks, if necessary. The best grade of bacteria-free milk must be gradually introduced when improvement has set in.

Next is quiet and fresh air. Babies suffer as much from being tossed about by the nurse as adults do from walking around. They should be kept quiet in the coach or on the bed. Playing about the floor should not be permitted. Fresh air, however gotten, is essential. Suburban trolley cars should be utilized by city dwellers as much as possible. Steamboat trips are also desirable in fine weather. Sponging with cool water is useful, and the infant should not be overdressed.

Mild cases need no medicine. More severe cases need only a primary purge of castor oil, which is far better than triturate tablets of calomel, as it has a secondary "binding influence." (We know of nothing more hopeless than a case of ileo-colitis aggravated by the injudicious use of calomel.) Bowel irrigation is beneficial in severe cases. The profession is now veering back the ground of a dozen years ago, and beginning to say that bowel irrigations have been much overdone and are rarely required. The truth lies between the extremes. Bismuth may be finally required to complete the cure. Opium should be avoided except in severe choleraic cases with pain.

C. Sigmund Raue, M.D.

CUPROL, A NEW MEDICAMENT FOR THE TREATMENT OF CONJUNCTIVITIS.—Cuprol is a combination of copper and nucleinic acid, containing 6 per cent. of copper. It is easily soluble in water, especially when warm. Both albuminous and alkaline solutions remain clear.

The solution of preference is one of 10 per cent. strength, to which may be added a half per cent. strength of chloretone as a preservative. The principal advantage of applications of this drug is their comparative freedom from pain, merely a slight burning sensation appearing about ten to twenty minutes after instillation. The author has employed the solution with success in the ordinary forms of conjunctivitis, and quotes the favorable results obtained from it by Snell in the treatment of trachoma.—Sicherer, Munich, *La Clinique Ophthal.*

William Spencer, M.D.

ACUTE MONOLATERAL RETROBULBAR NEURITIS DUE TO MENSTRUAL DISTURBANCE AT THE MENOPAUSE.—Stocke enumerates the ordinary causes of retrobulbar neuritis, and remarks on the possibility of complete cure of the condition if the macular fibres are not destroyed.

The author has observed a case in which the cause was menstrual in character, an etiological factor that has been rarely considered. The case, an hysterical, well-nourished woman of 45 years of age, had arrived at the age of menopause: the flow appearing irregularly at long intervals of time. On the sixth of the month cephalalgia and rachialgia developed, followed in three days' time, by a profuse menstrual flow. The day following, the patient felt as if a cord or a curtain were being drawn over the right eye.

Eight days later, she noticed on rising that the right eye was blind. External examination of the organ at this time revealed only a dilated pupil. The ophthalmoscope showed a slight irregularity of the retinal vessels. Vision was reduced to light perception.

Ocular motion and pressure on the globe produced pain in the base of the

orbit. Nine days after this, it is noted that the orbital pain and cephalalgia continued. At this time there was a relative central scotoma, though vision has increased to one-eighth of normal. The margins of the optic disc were indistinct, and the arteries on the nerve-head were slightly veiled and contracted. In about a month's time vision returned to normal.

The temporal segments of the nerve-head were atrophic, showing the lamina cribrosa. The retinal arteries were slightly contracted, and the corresponding veins were dilated. The fundus of the eye had assumed a dirty color.—Stocke, Beweren, Vaès, *La Clinique Ophthal.*

William Spencer, M.D.

THE USE OF IODIPIN IN OCULAR THERAPEUTICS.—Von Hymmen remarks on the discomforts which often accompany the employment of large doses of potassium iodid, and hence recommends iodipin, a combination of the oil of sesame and iodine. The drug is well borne, even for long periods of time. Its elimination is very slow, traces of it remaining in the urine fifty-three days after administration. It may be given by mouth in 10 per cent. strength, six teaspoonfuls a day, or as the oil enclosed in capsules. It may also be employed hypodermatically in ten to fifteen cg. doses of 25 per cent. strength solution every two three days. Iodipin, he says, can be given for all the conditions for which iodid of potassium has been used. He also states that it repeatedly succeeded in cases in which the latter drug had failed, not only in syphilitic affections, but also in cases of tumors and chronic inflammatory exudates, ocular palsies, etc.—*La Clinique Ophthal.*

William Spencer, M.D.

THE TREATMENT OF POSTPARTUM HÆMORRHAGE.—(Henkel.)—The usual methods of treating atony of the uterus are described in all text-books. Tamponade of the uterus is not always effective for the lack of counter-pressure from above, and if much blood has been lost it becomes so watery it will not coagulate readily but saturate the tampon and trickle through it. It is important therefore not too delay to long in using the tampon, as the saving of a very little extra blood may rescue the patient. The writer recommends that the tampon should be so used that the strips of guaze are introduced only into the lower segment of the uterus, so that the fundus can be anteфлекed firmly on the cervix and tamponed, and while it is in this position apply over it on the hypogastrium a large firm pad of cotton held firmly in place by a tight binder. Ergotin is recommended.

If, then, a deep laceration of the cervix is the cause of hæmorrhage, the writer uses with great advantage the Museaux forceps to compress the lacerated surfaces and the parametrium. The anterior and posterior lips are grasped in the median line by a pair of Museaux forceps. The cervix is thus drawn down to one side and a second Museaux grasps well up on the parametrium without regard to bladder, ureter or rectum, except it is well to have the latter protected by a fold of gauze under the blade of the forceps. The opposite parametrium is treated in like manner. The forceps are removed in 12 to 24 hours. Excellent results have been obtained at Olshausen's clinic in Berlin, and Prof. Olshausen prefers the clamp to suturing the laceration, as the latter diminishes the calibre of the cervical canal and interferes with drainage.

He gives morphia hypodermically after using the clamps to keep patients quiet, as anæmic patients are usually very restless. Plenty of drink should be

urged in small quantities. Rectal injections are not nearly so advantageous. Subcutaneous infusions of salt solution are very desirable, but not to the extent believed, as it dilutes the blood and makes it too watery to coagulate well. The ends of open blood-vessels should be sealed first to obtain the best effects of subcutaneous infusions.—*Zeitschrift für Geburtshilfe und Gynäkologie*. Bd. XLVII., H. 2, 1902.

George R. Southwick, M.D.

PERMANENT RESULTS OF ANTEFIXING OPERATIONS ON THE UTERUS.—(Cohn.)—The writer reviews 130 cases: 71 were movable retroflexions, 11 were ventral fixations, 21 were vaginal fixations, and in 39 Alexander's operation was performed. In the twenty-five fixed retroflexions ventral fixation was performed twenty times and vaginal fixation five times. Disease of the adnexa was present in thirty-four cases and was treated at the same time as the ventral fixation; thirty-nine Alexander operations, sixty-five ventral fixations and twenty-five vaginal fixations were examined later. The Alexander showed 15 per cent. of recurrences, the ventral fixation 6 per cent., and the vaginal 4 per cent. Vaginal fixation gave the worst results in subsequent labors.—*Centralblatt für Gynäkologie*, No. 25, 1902.

George R. Southwick, M.D.

THYROID EXTRACT IN DYSMENORRŒA.—(Stinson.)—Thyroid is a valuable remedy, and deserves the name of a uterine and ovarian alterative, anodyne and sedative. One grain in capsule is given three times a day for two days before menstruation, and increased to two grains three times a day during menstruation. He has used this remedy with most pleasant results, affording nearly perfect results in over eighty per cent. of cases.—*American Journal of Obstetrics*, July, 1902.

George R. Southwick, M.D.

RAPID DILATATION OF THE CERVIX WITH BOSSI'S DILATOR WITH SPECIAL REFERENCE TO ECLAMPSIA.—(Leopold.)—The writer has used it in fourteen cases with most excellent results. Twelve of the cases were most serious and the necessity for rapid delivery urgent. In all of these the cervix was either closed or only dilated the size of a quarter of a dollar. Complete dilatation without laceration or incision was effected in thirty minutes, so that the forceps could be applied and the patient delivered immediately. All the mothers were saved, and four of the infants. Eight infants from the sixth to the eighth month were lost. Rissman has used this dilator and praises it highly. The cervix does not thin or disappear as in normal labor but remains thick and contracts somewhat when the dilator is removed, especially in old primipare. Delivery should follow immediately after dilatation. If a laceration appears, put a rubber bag in the cervix and inflate it.—*Centralblatt für Gynäkologie*, Nos. 19 and 28, 1902.

George R. Southwick, M.D.

RETRODISPLACEMENTS OF THE UTERUS.—(Davenport.)—The writer recommends the Langford pessary, and suggests the following general principles:

1. Study the case. Determine the probable length of time that the displacement has lasted, its possible cause, the symptoms it has caused, their order of occurrence, and the relative importance of the general and local manifestations, and from these data form a careful opinion as to the chances of cure by one or the other method of treatment.

2. In a case of retroversion or flexion, always replace the uterus before adjusting the support. The pessary should not be relied upon to do this, as only in the rarest cases will it be possible.

3. In fitting a support choose one which fits exactly, if possible; but if not, have it too small, rather than too large.

4. The ideal pessary is one which supports the uterus perfectly without the patient being conscious of its presence.

5. The patient should be kept under observation while wearing the pessary and seen at regular intervals, preferably after each monthly period, for the cleansing of the support and its replacement.

6. When it is deemed wise to make an attempt to go without it it should not be removed at once, but a smaller one substituted, to be worn a month, and then a still smaller one, which finally may be removed.

The non-operative treatment of retroversion of the uterus has a place, and an important place, in our practice. The only method which merits an extended consideration is that by pessary. There are cases which are better treated by pessary than by operation, and there are not a few cases in which operation is the better, but in which it is refused and we are forced to use some non-operative measure.

For the vast majority of such cases the treatment by pessary is the only one that holds out any prospect of cure. In selected cases the chances of definite cure should be at least 50 per cent., but if we include in our statistics those cases in which we are *forced* to employ pessaries when our better judgment would select operation, the percentage of cases would not be more than 33 per cent. Cases which refuse operation should not be left untreated; for, even if a cure cannot be expected from the use of the pessary, it will often make the patient more comfortable.—*American Gynecology*, vol i., No. 1, 1902.

George R. Southwick, M.D.

THE ALCOHOL THERAPEUTICS OF PUERPERAL FEVER.—(Kantorowicz.)—It does not lower the pulse or the temperature nor have any useful effect. The use of it to bathe the patient is most beneficial. It lowers the fever and increases the appetite. The symptoms of delirium, somnolence and cerebral irritation sometimes seen in sepsis are due to the alcohol taken and not to the septic infection. Alcohol in large doses in thoroughly septic cases is poisonous, injures the heart and prolongs convalescence.—*Centralblatt für Gynäkologie*, No. 18, 1902.

George R. Southwick, M.D.

THE TREATMENT OF RETROFLEXION AND PROLAPSE OF THE UTERUS.—(Andersch.)—The writer gives the following summary after a critical study of a large number of cases operated upon:

1. Treat all movable retroflexions with or without prolapse or descent, so far as possible, with pessaries.

2. If treatment by pessaries fail, vaginal fixation is recommended.

3. Rare cases of movable retroflexions of the uterus may be treated by ventral fixation or by Alexander's operation.

4. All fixed retrodeviations require ventral fixation.—*Archiv für Gynäkologie*, Bd. 65, H. 2, 1902.

George R. Southwick, M.D.

THE ALEXANDER OPERATION.—(Cleveland.)—The writer is convinced of the efficacy of this operation in properly selected cases. The uterus should be freely movable, capable of being replaced and retained in position by a pessary. If adhesions are present they can be broken up by opening the posterior cul-de-sac; but even then Alexander's operation is not indicated, and it is better to open the abdomen and use some other method. A person with some constitutional dyscrasia is not a fit subject for the operation.

When procidentia exists, shortening of the round ligaments is not indicated even as an aid or adjunct to the necessary plastic work, and it is very doubtful if it is of much avail in mere prolapsus. An exceedingly heavy uterus or one weighed down by a fibroid is not a promising case for operation, some of the best results have been obtained in anterior displacements. When shortening of the round ligaments is not indicated he recommends Bissell's operation. It consists of cutting out a section of each round ligament, sewing the ends together, then stretching out the rent in the broad ligaments in opposite directions and sewing them together at right angles to the round ligament. It shortens both the round and broad ligaments, and gives excellent and lasting results. The adjustment of a pessary is a preliminary step to the Alexander operation, and it always should be worn two months after the operation. A particularly good description of this operation is given in this article. In over three hundred cases many have borne children since the operation without suffering from displacement; but these cases should wear a pessary a few months after confinement. The uterus cannot be anteflexed by drawing the round ligaments too tightly, as has been claimed.—*American Gynecology*, vol. i., No. 1, 1902.

George R. Southwick, M.D.

THE DIAGNOSIS OF MALARIA.—The London correspondent of the *Medical Record* (June 21, 1902) quotes with considerable detail Dr. Patrick Manson's recent discourse before the Medical Society. Recent discoveries, Dr. Manson asserts, enable us to be absolutely sure of the diagnosis in ninety-nine cases out of a hundred. The pathognomonic indications he arranged as (1) clinical, (2) therapeutical, (3) microscopical. The only classical symptom justifying a diagnosis of malaria was periodicity—but that only tertian or quartan. The appearance of a quotidian periodicity, he said, was common enough in malaria, but it was only an appearance. It was doubtful whether true quotidian periodicity ever occurs; the parasites are tertian or quartan in habit, and the recurrence of the symptoms corresponds. Multiple infection may give rise to diurnal return of symptoms, but that is not true quotidian periodicity, whatever it may be clinically.

Therapeutic diagnosis resolved itself into the effect of quinine. In England it never failed to arrest an attack. Persistence after four days' dosing (10 gr., t. i. d.) proves the case is not malarial. But the quinine must, of course, be absorbed. Often, on account of the state of the stomach, we must resort to enemas or hypodermic injections. Tablets and coated pills are dangerous.

Microscopical diagnosis is the most satisfactory if the observer has experience. The beginner cannot expect to obtain reliable results. It is easy enough when one has been properly taught, and then has had large experience. Every practitioner should learn to prepare blood-films fit to submit to an expert. The patient must not have taken quinine recently, for even in small doses it

will cause the disappearance of the parasites temporarily, and sometimes for a long time.

Dr. Manson repudiates a rather common opinion that the infection may last a lifetime. He believes that a malignant tertian tends to die out in from one and a half to two years, a benign tertian in two to two and a half years, and a quartan in about three years. Old Indians talk of jungle fever when they get a feverish cold, which others call influenza or something else. Dr. Manson has seen many reputedly malarial patients from places in England formerly malarious, but they turned out to be something else. He believes the plasmodium has died out in England, like the wolf and the wild boar.

As a special hint, he added that a positive diagnosis of malaria does not exclude other diseases, but rather predisposes to them. So, too, an explosion of malaria is favored by other infections, especially typhoid and tubercle.

We have known for some years that during and after malarial attacks the leucocytes are diminished in proportion to the red corpuscles, the diminution being chiefly the polymorphonuclears, so that there is a relative increase in the large mononuclears. This does not seem to be affected by the use of quinine, and so has been considered a diagnostic indication. Drs. Christophers and Stephens reported to the Royal Society that an increase of mononuclears "beyond 15 per cent. is proof of an actual or recent malarial infection." Captain Rogers, I. M. S., endorses this, and so does Dr. C. W. Daniels, Superintendent of the Tropical School. The latter has had great experience, and is fortified in his conclusions by other observers. He puts the value of the test as about equal to that of agglutination in typhoid fever.

F. Mortimer Lawrence, M.D.

BLOOD-COUNT IN VARIOLA AND VARICELLA.—E. Weill and A. Decos have shown by numerous observations that varicella does not present any profound modification in the cellular elements of the blood, differing in this respect from variola. In the latter disease the blood has the following features: The red-blood cells are diminished in number, and nucleated red-blood cells are almost always to be found. There is a constant hyperleucocytes. The polymorphonuclear leucocytoses are diminished in number, and the mononuclear leucocytes are increased. There is an augmentation in the number of the large mononuclear leucocytes, with pale nucleus. Myelocytes are always present, and in a marked proportion. In contrast to the distinct changes in the blood of variola, the blood of varicella shows the following characteristics: The number of red-blood cells is normal, and there are no nucleated red-blood cells. There is little or no leucocytosis. The polymorphonuclear leucocytes are normal or slightly increased, while the mononuclear variety are normal or slightly diminished. The large mononuclear leucocytes with pale nuclei are normal or even diminished in number. Myelocytes are absent. The authors conclude from the above observations that the blood-count in varicella differs markedly from that in variola, and that the examination of the blood is of eminent value in the diagnosis of these two affections, particularly when very difficult in the beginning of the disease.—*Jour. de Physiol. et de Pathol. Gen.*, May 15, 1902.

W. Howard Lyle, M.D.

THE BLOOD IN TYPHOID AND MALARIA.—Leonard Rogers has carried out a series of observations on some fifty cases of continued and remittent fevers, and has come to the following conclusions:

1. The percentage of the different forms of leucocytes counted in a stained blood-film is of great diagnostic value in differentiating typhoid and malarial remittent fevers, and is easily ascertained.

2. An increase of lymphocytes to 40 per cent. or over, without any increase in the large mononuclears, points to typhoid as against malarial fever.

3. An increase in the large mononuclears to about 12 per cent. and upward, especially during the remissions of the temperature, strongly indicates malaria as against typhoid fever. This change is of great value when parasites are absent from the blood.

4. The presence of myelocytes in any number, such as from 1 to 5 per cent., points to malarial as against typhoid fever.

5. A high degree of anæmia, such as a reduction of the red-corpuscles to below 3,000,000 per mm., is much more frequently met with in malaria than in typhoid fever.

6. A very great reduction in the total leucocyte-count, such as to below 2000 per mm., is much more frequently met with in malaria than in typhoid fever, while the proportion of white to red corpuscles in malaria is not frequently less than 1 to 2000, which is rare in typhoid fever.

7. Leucocytosis can be detected by the presence of a great excess of white corpuscles, upward of 80 per cent. of which are polynuclears, in a stained blood-film, and is often of service in excluding malaria in intermittent fever due to liver abscess or other local inflammations.—*British Med. Jour.*, April 5, 1902.

W. Howard Lyle, M.D.

THE BABINSKI TOE-REFLEX.—The Babinski toe-reflex, a dorsal flexion of the big toe after irritation of the plantar surface of the foot, which has been supposed to indicate a lesion in the pyramidal tracts, has been tested by Levi (*Munch. Med. Woch.*, May 27, 1902) in a large number of cases, and found to be not entirely reliable. In 6 per cent. of the cases in which disease of the pyramidal tracts could be definitely excluded the reaction proved positive, and of the remaining 94 per cent. of cases only 86 per cent. gave a distinct reflex. In paralysis agitans, Huntingdon's chorea and epilepsy, the phenomenon never occurred. In two cases of recent hemiplegia the reaction was present, but disappeared in a few days. That increased knee-jerks in general paresis do not always signify pyramidal destruction seems possible from the frequency with which no Babinski reflex could be obtained; and, conversely, quite a few cases came under observation in which a Babinski reflex and absence of knee-jerks went together.—*Med. News*, July 26, 1902.

F. Mortimer Lawrence, M.D.

THE BACTERIOLOGY OF RHEUMATIC FEVER.—Lartigau (*Albany Medical Annals*, May, 1892) reaches the following conclusions:

1. Acute articular rheumatism is an infectious disease, very probably induced by a specific bacterial excitant.

2. The claims of Achalmé and others that the infection is attributable to an anaerobic bacillus have not been sustained and are very probably untenable.

3. The correctness of the contention advanced by Singer that the disease is a modified pyæmia is very doubtful. It is probably much safer to say that secondary infection with pyococcal bacteria is common in this disease.

4. The diplococcus isolated by Wasserman, Poynton and Payne, and several

others, is probably a modified streptococcus. All of the inoculation results induced by this assumed specific diplococcus may be obtained with the streptococcus pyogenes. The demonstration of this organism, then, as the causative factor of rheumatic fever is incomplete.

5. The specific bacterial excitant of the disease still remains to be discovered.

F. Mortimer Lawrence, M.D.

THE ŒDEMA OF ANÆMIA.—Houston, from a thorough study of the subject, concludes that,

1. The absence of loss of weight in anæmic conditions, and the fact that the patient seldom seems emaciated, is mainly due to the fact that there is an abnormal accumulation of fluid in the blood and tissues. If this excess of fluid were deducted, it would probably be found that in these, as in other chronic illnesses, there is a progressive loss of weight in proportion to the severity and duration of the disease.

2. In the cure of such anæmic conditions, especially chlorosis, the first stage seems to be the getting rid from the blood and tissues of this excess of fluid.

3. A gain in weight in a case of pernicious anæmia under treatment, and without any improvement in the hæmoglobin, is to be regarded as an unfavorable sign, indicating dilution of the blood and consequent escape of serum into the tissues. It may, however, be a critical phase of the disease, and indicate the first step toward concentration of the blood. Immediately after this sudden increase in œdema there is either a marked improvement or the patient dies.

4. The œdema of anæmic conditions seems to result from a hydræmic plethora of the blood, and is somewhat different in origin and nature from the œdema usually found in Bright's disease.

5. Careful observations of anæmic conditions in the manner indicated, namely, a record of the weight and hemoglobin value of the blood, may furnish very interesting results. The points to which to direct attention are the occurrence of hæmorrhages (epistaxis, etc.), œdema, diarrhœa, and profuse sweating, which symptoms are often the result of dilution of the blood, and may be merely nature's method of counteracting the excessive and abnormal volume of the blood.—*Brit. Med. Jour.*, June 14, 1902.

F. Mortimer Lawrence, M.D.

THE MALARIAL ORIGIN OF ZOSTER.—Winfield has examined 25 cases of herpes zoster, 19 males and 6 females, ranging in age from 9 to 50 years. All the patients had symptoms of some infection, either malarial or intoxication due to some other organism, and 14 gave positive evidence of paludism by the presence of the malarial parasite in the blood. Fifteen of the patients had intercostal zoster; in two the eruption occurred on the face, neck and shoulder, in two it was over the gluteal region, in two over the neck and occiput, in one the side of the face and neck was involved, one was of the ophthalmic variety, another was over the lumbar region, and another began on the neck and extended down the arm. One case was bilateral, and one was recurrent. The author reviews the literature of the subject, and cites many similar cases, among which are eight previously reported by him, in which four showed the malarial plasmodium in the blood. He does not contend that this organism is the only causative agent in zoster, but that many varieties of bacterial intoxication bring about the same effect.—*N. Y. Med. Jour.*, Aug. 2, 1902.

F. Mortimer Lawrence, M.D.

THERAPEUTIC USES OF THE X-RAY.—Evidences of value of the X-ray in the treatment of superficial cancer and lupus are multiplying rapidly. Bon-durant (*N. Y. Med. Jour.*, Aug. 2, 1902) records the successful treatment of several cases. One was a long-standing carcinoma of the face in a man of middle life, who had previously tried almost every known treatment without success. The carcinomatous area was treated by exposure to the rays generated in a medium vacuum Crookes tube for 10 minutes every other day. After two weeks the pain ceased entirely, and within a month there was no discharge and no bad odor, and the deeper portions of the ragged cavity were beginning to show healthy granulations. The healing process is steadily progressing. A second case is one of apparent cure of an epithelioma of the face which had been twice removed. He also reports a case of lupus, which, after ten sittings, showed healing of the ulcerated surface, and shrunken nodules.

F. Mortimer Lawrence, M.D.

HYPNOTISM IN THE TREATMENT OF THE MORPHINE HABIT.—Agatson reports a case of the morphine habit in a patient who was in the habit of taking twenty-five grains of morphine daily. The nausea, vomiting, diarrhœa, colic, insomnia and restlessness nearly unsettled the patient's mind, and substitute drugs proved unavailing. Finally hypnotism was attempted, and by this means several hours' sound sleep were obtained on the first night. The patient was hypnotized each night subsequently, and the rest thus obtained enabled her to resist the habit.—*N. Y. Med. Jour.*, May 17, 1902.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF ANGINA PECTORIS.—Perkins (Providence, R. I.), believes that the important thing in treatment is to search out the cause of the disease and the exciting causes of the attacks, and so far as possible remove them. Of drugs, the one which seems to be of the greatest value is potassium iodide, given in moderate doses, not more than 10 or 15 grains three times a day for a long time. During the attacks, nitroglycerine is the best in many cases. Frequently, however, the only drug that will give relief is morphine, and sometimes a good deal of it is needed. The cause of the pain is not known, but it has been compared to that occurring in other hollow organs, as in renal and biliary colic, and it seems that the same precautions should be used in the administration of morphine, for here and there the paroxysms may end suddenly, and then the poisonous symptoms due to the morphine will prevail. Therefore, if the pain is not controlled soon by morphine, the author would use chloroform or ether.—*American Medicine*, Aug. 23, 1902.

F. Mortimer Lawrence, M.D.

THE PHYSICAL TREATMENT OF TUBERCULOSIS.—Le Fevre (New York) called the attention of the American Therapeutic Society to the use of physical means in the treatment of tuberculosis. Well-regulated exercise should be taken, according to the stage of the disease and the condition of the patient. Always avoid fatigue. In the early state of the disease rest is most important. He also called attention to the use of the pneumatic tablet. This instrument for the treatment of tuberculosis was killed by over-enthusiasm on the part of the profession.—*Medical News*, July 5, 1902.

F. Mortimer Lawrence, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

CONDUCTED BY O. S. HAINES, M.D.,

with the collaboration in German literature of C. Sigmund Raue, M.D.

MORE SIGNS.—Dr. William Colby Cooper thinks that drugs, in common with other things that are foreign to the organism, are its natural enemies. Each drug possesses a hostile affinity for a specific tissue or organ or part. Drugs being enemies, and not friends of the animal organism, do not cure by supplying chemical or histogenic lacks. They cure by *shock*, general or local, or by both. The author believes, too, that it is left to poor mortal man to find out for himself how, when and where to give drugs, and that we must ascertain these things through pure, bald, stark empiricism. We must learn by experimentation how each particular drug impresses a particular part, or rather we must learn what particular tissue, or organ, it expresses itself upon. The homœopathist does this by provings upon the healthy organism, and Dr. Cooper thinks the practice a most excellent one. He also believes that the homœopathic law of similars is immutable, and that the essential difference between homœopathy and modern eclectism is very small, whether we like it or not.—*Eclectic Medical Gleaner*.

PELVIC PERITONITIS.—Where there is chronic specific trouble resulting in abscess and adhesions, we must resort to surgical measures. Too often such cases are curetted when the tubes demand removal. In other forms of peritonitis with the symptoms of persistent vomiting, excruciating cutting pains, tympanitis, especially around the navel, with flexed thighs, moist skin and pinched countenance, colocynth will often relieve like magic.

But where there is great thirst, the lips parched, the tongue coated white or a dark brown, offensive breath, headache, lancinating pains shooting through the abdomen and pelvis, the patient very irritable, not wishing to be disturbed, we must choose *bryonia alba*.

Should the pains be of a sharp, stinging character, and lingering, more prominent in the right iliac region, the disease past the exudative stage, adhesions taking place, the urine dark-brown and quite scanty, containing albumin, the patient, having lost appetite and feeling, very stupid and exhausted, *apis mellifica* will often make the woman well.—James B. Brown, M.D., in *Hom. Journal of Obstetrics*.

NOTES ON ZINCUM SULPH.—Dr. J. A. Wakeman extols the virtues of zincum sulph. in the condition which he terms hyperæsthesia or morbid sensitiveness. The prominent symptom of this condition seems to be a state of "fidgetiness" and restlessness in the lower limbs, and especially in the feet.

Whether it is a hyperæsthesia or lumbar hyperæmia that causes this restlessness, it is often kept up by some irritation in the pelvic or generative organs, and will only pass away when the cause has been removed. It has been noticed that the symptoms are worse at night, particularly before twelve o'clock. The patient is unable to remain quiet after retiring. A strange and indescribable sensation commences about the pelvis and passes down one or both limbs in a wave like sensation, which is more unbearable than actual pain. Partial relief is obtained by walking or by movement of feet and limbs. This sounds very much like the familiar "fidgety feet" of zincum. We have often met with it, and generally have succeeded in curing these cases with either zincum met. or zincum val., in third or sixth trituration. Dr. Wakeman praises the efficacy of the Zincum sulph. in 45 m. or even in c.m. potencies.—*Hom. Recorder*, June 15th.

SOMETHING FOR HOMŒOPATHS TO THINK OVER.—Dr. Walter Wesselhoeft is spending some time abroad, investigating the methods of those teachers who are doing the most to further the soundest therapeutic principles. In an interesting letter to The Hughes Medical Club, a splendid organization of New England homœopaths, he refers to the labors of Prof. Schultz of Greifswald. This eminent scientist has been preaching to his students, and publishing, certain therapeutic doctrines, which, by no means, meet the approval of the great and mighty who know it all. This independent man shows to his pupils the futility of animal experiments, which the learned perform with so much skill in the presence of their classes; and of the clinical experiments at the bedside with drugs about which nothing is known save crude drug effects. He emphasizes the need of thorough provings of drugs upon the healthy, as the only essential link to connect animal experiments and clinical ones. He teaches the importance of a consideration of Arnot's law, the operation of which is seen in the fact that a slight irritation arouses vital activity to the normal point, a stronger irritation to an abnormal one; while a very strong irritation checks or paralyses it. Another law, he says, to be borne in mind in the demonstration of drugs, is that of Ritterballi. This proves that the more feeble, the more depressed or exhausted the controlling centres of various physiological functions, the more powerfully they respond to the gentler irritation. A healthy nerve, freshly exposed, calls for a vigorous irritation to cause it to respond. A feeble nerve, nearing its extinction or its vitality, will promptly react on the application of a stimulus so gentle that the healthy nerve would remain unaffected. "What does all this mean," asks Prof. Schultz, "if not that drug action is subject to laws, as well as every other vital presence?" We must know, by careful drug proving, the elective affinity of the organs, tissues and cells for certain medicinal substances. This, again, points to a law, namely this: Drugs, in order to produce a curative effect in a given class of cases, must have a specific relation to the parts affected; and this specific relation is expressed by the formula, "*similia similibus curantur*." The Professor then tells his students that if this statement smacks too strongly of homœopathy, and distresses them, that he is sorry; but that he defies any one to prove that such teaching is not scientifically sound and of great practical value. It must be borne in mind that such teaching is from the lips of an eminent professor in a German university. It need not be added that the ministry of education frowns upon it heavily, neglects this department,

ignores the writings of Dr. Schultz, and behaves generally in an unbecoming, allopathic manner. And so it seems to us that the signs of the times are pointing to a some-day recognition of the basic truths of our science by the mass of the profession. A wilful indisposition to recognize truth, is the only thing that can prevent such a happy issue from all the difficulties and dissensions that separate the schools of medicine. (The facts regarding Dr. Schultz's lecture were taken from Dr. Wesselhoeft's letter, in July *New England Med. Gazette*.)

SOME REMEDIES IN DISTURBANCES OF BILE SECRETION.—In the *Homeopathischen Monatsblätter* (July, 1902), Dr. Donner (who, by the way is one of the best known German homœopathic writers in clinical medicine) writes a most comprehensive article on disturbed biliary secretion. He discusses its pathological significance and gives the homœopathic therapeutic indications for the remedies showing a selective affinity for this important function. "In cirrhosis of the liver," says Dr. Donner, "I give *leptandra virginica*, first potency, but only when the liver is still swollen and not yet contracted; the urine is dark, the stool black and the tongue yellow. Also in the severe hepatic degenerations following infection I prescribe *leptandra* in the early stages; later *phosphorus*, 3., *arsenicum*, 3., *lachesis*, 6-30., *naja trip.*, 7-30., or *crotalus*, 6-30.

"In more advanced cases of cirrhosis of the liver *laurocerasus*, tincture, has proven useful for a period of time, and given in conjunction with *aurum jodat.*, first trituration, has expanded the time between the necessary tappings of the abdomen to much longer intervals."

Concerning stimulation of the biliary secretion he says: "The old school do not believe in the power of medicaments to increase the flow of bile by direct action on the biliary secretion, but I do not care to agree with them on this point, for we have in our *materia medica* a list of good remedies that excite the secretion of bile and thereby increase the flow of the same. I shall only mention *lycopodium*, *chelidonium*, *bryonia*, *sulphur* and *phosphorus*."

ANTIRRHINUM LINARIA.—This remedy has recently been recommended by Dr. V. Lukowsky, a Russian homœopathic physician, as a local application in various cutaneous eruptions. Proving of *antirrhinum* has elicited the following symptoms: Great somnolence with pressure in the forehead and fulness in the head; dryness and burning of the tongue, expanding into œsophagus and inducing a dry, irritating cough; sense of constriction in throat; pressure on chest with dyspnoea; empty eructations and pressure in stomach; colic; watery stools.

Farrington recommended it for retention of urine and dysuria. No specific action on the skin has been observed.—*Homeopathischen Monatsblätter*, June, 1902.

DIABETES INSIPIDUS.—In this affection you will naturally seek medicines of the order "diuretics." Of these, *scilla* deserves our best attention. Dr. Richard Hughes speaks highly of this remedy, and mentions the case of an Indian officer who had for two years been passing an inordinate quantity of pale urine. There were no special symptoms present, but the drain seemed to keep his health and strength below par. Phosphoric acid did him no good. *Scilla* 2, three drops, three times daily, cured him. The doctor wrote that

he had used this remedy in other similar cases with curative results. We must not forget, however, that diabetes insipidus often depends upon incurable lesions of that part of the brain whose irritation can set it up, and that the prognosis is sometimes very unfavorable.

BAPTISIA AS AN ABORTIVE REMEDY IN FEVERS.—Richard Hughes maintained that there is, over and above the four types of idiopathic fever generally recognized,—typhus, typhoid, relapsing and febricula,—a *common continued fever*, the “gastric” of our popular nomenclature. This is sometimes epidemic, often severe, and under such remedies as aconite, bryonia, or rhus, may run a protracted course and even end fatally. In this form of fever baptisia may be depended upon to abort or cut short the attack. The remedy should be given repeatedly, and in low dilution. Dr. Hughes, during the latter portion of his life, was inclined to think that true typhoid fever could not be aborted by any treatment, and thought the reports of such success should be considered as more likely cases of this common continued fever, in the treatment of which baptisia is so useful.

ABSTRACTS FROM THE MINUTES OF THE BERLIN SOCIETY OF THE HOMÖOPATHIC PHYSICIANS, March, 1902.—*Ceanothus Americanus*.—Dr. Kröner made the following remarks concerning this remedy. It exerts a specific effect upon the spleen. The symptoms are left-sided. There is enlargement of the spleen; dyspnœa; profuse nausea and leucorrhœa; inability to lie on left side; pain in the liver.

Diarrhœa: Downward pressure in the rectum and in the abdomen.

Urine: Green, foamy, containing sugar and bile.

Moxalities: Aggravation from motion and from lying on left side.

Dosage: First dilution.

Dr. Gisevius, Jr., related from his experience that *ceanothus* was only of value clinically in splenic tumor resulting from malaria. In other forms of enlargement of the spleen it has never given him results.

Cedron.—Dr. Gisevius cured a case of malarial neuralgia with this remedy. The comparisons of *cedron* with *ceanothus* is interesting.

Both are applicable in periodic neuralgias; *ceanothus*, however, only in malarial, while *cedron* suits non-malarial cases as well.

Arsenic in Malarial Cachexia.—Dr. Burkhard reported the case of a man who contracted malaria in New Guinea, and who was taking 7-gram doses of quinine. There was a quinine rash and enormous swelling of the spleen. A prompt cure followed the administration of arsenic.

Chininum Arsenicosum in Interstitial Keratitis.—A young girl who had been treated unsuccessfully with mercury for an interstitial keratitis, was put on *chininum arsenicosum*, with prompt recovery (Gisevius).

Tuberculinum in Basilar Meningitis.—According to Dr. Nebel (*Zeitschrift des Berliner Vereins Hom. Aerzte*), *tuberculinum* is indicated in basilar meningitis when critical evacuations are present; sweat, increased urinary excretion, diarrhœa, exanthemata. At the same time he employs hot baths and hot compresses to the head. He mentions a case in which there was rolling of the head, deafness, and paralysis of the right leg and arm that recovered under the administration of *tuberculin*. *Tarantula*, sulphur, silicon and calc. carb. were, however, also employed during the progress of the case.

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EDITED BY

HERBERT P. LEOPOLD, M.D.

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Diseases of the Lungs. By A. L. Blackwood, M.D., Professor of General Medicine and Senior Professor of Physiology in the Hahnemann Medical College, Chicago; Attending Physician to the Hahnemann Hospital, Chicago; Associate Physician to Cook County Hospital, etc. Halsey Bros. Co., Chicago and St. Paul. 1902.

Professor Blackwood is already known to us not only as a successful teacher and clinician, but also by his valuable work on "Diseases of the Heart." We have, therefore, looked forward with great interest to the appearance of his

companion volume dealing with diseases of the lungs, and the book now lies before us. It requires but a glance to see that the work is, above all things, practical. Theories have been omitted; details of etiology and pathology, while by no means slighted, have been restricted in space; and the bulk of the volume is devoted to the diagnosis and treatment of pulmonary disease. This, as the author states, is the primary object of the work; and it is an object admirably achieved. To further elucidate differential diagnosis, many tabulations in parallel columns have been introduced; and, in addition, the characteristic symptoms and physical signs are described with a simplicity and directness which should render their detection easy even by the inexperienced. In therapeutics it is evident that the author, while a firm believer in homœopathy, is no bigot. He prefaces his section on treatment by well-chosen directions as to the general management and auxiliary measures, and this is followed by clean-cut indications for the various remedies, which are presented in the order of their importance as observed by the author. It is evident that the book from cover to cover is clinical, the work of a practical physician and experienced teacher. We need more of such books.

A Text-Book of Physiological and Pathological Chemistry. By G. Bunge, Professor of Physiological Chemistry at Bâle. Second English Edition, translated from the Fourth German Edition by Florence A. Starling, and edited by Ernest H. Starling, M.D., F.R.S., Professor of Physiology in University College, London. Philadelphia: P. Blakiston's Son & Co. 1902. Price, \$3.00 net.

It has been pointed out, notably by Osler, that the resources of the dead-room and the microscopical laboratory are about exhausted, and that for future advances we must look to the discoveries of the physiological chemist. That the truth of this statement is generally appreciated is shown not only by the tendency of the younger investigators to make the chemical laboratory their field of effort, but by the greater attention given to the instruction of undergraduates in the fundamental data of physiological chemistry. Under the circumstances, the work of Professor Bunge is a boon to the entire medical profession. Its author was a philosopher, a mathematician and a chemist before he became a physiologist. He represents pre-eminently the investigations of Schmiedeberg and his pupils, whose notable researches have included the synthesis of hippuric acid in the kidney, the details of the formation of urea, the production of diabetes by extirpation of the pancreas, and a vast number of other matters of great bio-chemical importance. The author has wisely omitted isolated facts and descriptions of analytic methods, access to which can readily be had through his extensive bibliographical references, and has, instead, given an account of the ascertained facts of physiological chemistry in a style so attractive, so interspersed with philosophical appreciations of the relationship of his facts to the mysteries of life and death, that even the beginner must become interested at once. The translation into English has been ably done, and the result is a volume whose charm will carry it into the library not only of the worker in physiological chemistry, but of every physician whose general culture enables him to mingle an appreciation of general philosophical thought with the practical problems of every-day life.

A Treatise on Diseases of the Skin. For the use of Advanced Students and Practitioners. By Henry W. Stelwagon, M.D., Ph.D., Clinical Professor of Dermatology, Jefferson Medical College and Woman's Medical College, Philadelphia; Dermatologist to the Howard and Philadelphia Hospitals. Handsome octavo of 1125 pages, with 220 text-illustrations, and 26 full-page lithographic and half-tone plates. Philadelphia and London: W. B. Saunders and Co. 1902. Cloth, \$6.00 net; sheep or half-morocco, \$7.00 net.

This book presents the practical part of the science of dermatology in a sufficiently full and complete manner to make the work one that will give the general practitioner a clear comprehension of the symptomatology, diagnosis and treatment of the various affections with which he is most likely to come in contact. Diagnosis, the most difficult and confusing part of cutaneous medicine, has been accorded considerable attention, and the elaborate remarks under "General Diagnosis" will be found of substantial aid in narrowing the diagnostic possibilities. Treatment has been detailed with clearness and accuracy, the author referring not only to the remedies and methods used in his own practice, but to those employed and advised by others.

Etiology and pathology have not been neglected, and the clinical and pathological aspects are further elucidated by a large number of beautiful illustrations, mainly from the author's own collection, besides a number of colored lithographic plates of exceptional merit. The work, though planned for the student and general physician, will unquestionably be found of material assistance to the dermatologist.

International Clinics. A quarterly of illustrated clinical lectures and especially prepared articles by leading members of the medical profession throughout the world. Edited by Henry W. Cattell, A.M., M.D., Philadelphia, U. S. A. Volume II. Twelfth Series, 1902. Philadelphia: J. B. Lippincott Company. 1902.

The current volume of the *International Clinics* is notable for its contributions to practical medicine. No less than seven articles by continental authorities, including Lepine on diabetes mellitus, Finger on acute urethritis, and Robin on ulcer of the stomach, deal with therapeutics. Not less impressive are the clinical lectures on pachymeningitis hæmorrhagica, by Pick; on pseudo-leukæmia with chronic relapsing fever, by Vickery; and on gastro-intestinal auto-intoxication, by Hemmeter. These are but a few of the articles dealing with medical topics. Among the surgical subjects are resection of the cervical sympathetic, by Jomescu, of Bucharest; perforating bullet-wounds of the nervous system, by Gibbs, of London; and the treatment of acute appendicitis, by Walker, of New York. Clinical lectures by Coley, of New York, and Senn, of Chicago, are also included. Howard Kelly, of Baltimore, contributes a discussion of a variety of gynæcological details. There is a biographical sketch of John B. Murphy, M.D., of Chicago; and in addition there are three special articles: "An Outline of the Organization and Work of the Medical Department of the United States Army," by E. L. Munson, M.D.; "Some Notes upon the Management of a Modern Private Hospital," by H. A. Kelly, M.D.; and "The Functions of the Digestive Gland, from the Researches of Prof. I. P. Pavlov and his Pupils," by Peter Borissof, M.D. The volume is handsomely printed and well illustrated, and is calculated to appeal to physicians of every class.

Practical Dietetics, with Special Reference to Diet in Disease. By W. Gilman Thompson, M.D., Professor of Medicine in the Cornell University Medical College, New York City, and Visiting Physician to the Presbyterian and Bellevue Hospitals. Second edition, enlarged and thoroughly revised. D. Appleton and Co., New York. 1902.

It hardly seems necessary to call the attention of the profession to Dr. Thompson's work on dietetics, as it is universally conceded to be one of the finest works on the subject, and attained wide popularity and reputation upon its first appearance. Now, however, that we are favored with a second edition, fully revised and brought up to date in every respect, we read it with renewed interest. This work is decidedly an American product, unique in its arrange-

ment, exhaustive in its treatment, and eminently practical. Its most commendable feature is the application of dietetic principles to clinical medicine. Dr. Thompson rides no hobbies, and in this respect differs from his distinguished colleague in England, Sir Henry Thompson. Referring to the latter's condemnation of the use of meat in our daily diet, he says: "Training has become so strongly a matter of heredity through many centuries that those who possess it are certainly in better health for a reasonable amount of meat in their dietary, and many primitive savage tribes have always subsisted largely upon meat."

Diet in disease is most expansively considered, and complete and reliable dietaries for every ailment are suggested. The dietetic errors responsible for a large number of diseases are also fully discussed. Altogether, it is perhaps the best work extant on the subject of dietetics.

Clinical Lectures on Surgical Subjects. Delivered in University College Hospital by Christopher Heath, Past President of the Royal College of Surgeons of England, Emeritus Professor of Clinical Surgery in University College, London, and Consulting Surgeon to University College Hospital. Second Series. Philadelphia: P. Blakiston's Son & Co. 1902. Price, \$2.00 net.

In this volume the author has brought together a number of the clinical lectures delivered by him during the past few years. Two of them, those dealing with diseases of the joints and with aneurysm, respectively, formed part of the Lane lectures delivered in San Francisco in 1897. In addition, there is a *resume*, "A Century of Surgery," and the Hunterian lecture for 1897. The remaining lectures, thirteen in number, deal with leg ulcers, fractures of the lower limb, diseases of the rectum, tetanus, meningocele and encephalocele, amputation for tubercular joint disease, gangrene of the leg, fracture of the base of the skull, epithelioma and rodent ulcer, distal ligature in the treatment of aneurysm, and thyroid cyst. In addition to being extremely readable, the lectures are filled with practical suggestions as to treatment, and will appeal quite as much to the general practitioner as to the surgical specialist.

Atlas and Epitome of Abdominal Hernias. By Privatdocent Dr. Georg Sultan, of Gottingen. Edited, with additions, by William B. Coley, M.D., Clinical Lecturer on Surgery, Columbia University (College of Physicians and Surgeons). With 119 illustrations, 36 of them in colors, and 277 pages of text. Philadelphia and London: W. B. Saunders & Co. 1902. Cloth, \$3.00 net.

This new addition to Saunders's series of Medical Hand-Atlases covers one of the most important subjects in the entire domain of medical teaching, since these hernias are exceedingly common, and the frequent occurrence of strangulation demands quick and energetic surgical intervention. While the well-known work of Macready will always remain a classic, it has never claimed to deal with the operative side of the subject, and this is a side that, during the last decade, has been steadily growing in importance, until now it is absolutely essential to have a book treating of the surgical aspect of the subject. This present atlas does this to an admirable degree, and, without question, will prove of very great value to the general surgeon and practitioner. The illustrations are not only numerous, but they excel, in the accuracy of the portrayal of the conditions represented, those of any other work upon abdominal hernias with which we are familiar. Indeed, like all the other numbers of this excellent series, the work is a worthy exponent of our present knowledge of the subject, and in its field is unrivalled.

The Gouty at Aix-les-Bains ; Diet and Treatment. By Leon Blanc, M.D. Paris and London : J. & A. Churchill ; Philadelphia : P. Blakiston's Son & Co. 1902.

This little brochure, written by a physician of Aix-les-Bains, is evidently intended to explain and justify the thermal treatment in vogue at that resort, especially when combined with a special acid diet. The author contends, and advances both reasons and authorities for his contention, that acids have the extraordinary property of decreasing the production of uric acid and increasing the urinary alkalinity. This is associated with the use of the douche, with massage, and the internal use of the waters ; and, according to the author, " the gouty subject can hope for an almost certain recovery if he shows perseverance in this treatment and the prescribed diet and regimen." While the same claim can be made for many systems of treatment, provided proper diet and regimen be observed, Dr. Blanc's book is well worth the few moments required for its perusal.

A Manual of Instruction in the Principles of Prompt Aid to the Injured, including a Chapter on Hygiene and the Drill Regulations for the Hospital Corps, U. S. A. Designed for military and civil use. By Alvah H. Doty, M.D., Health Officer to the Port of New York ; late Major and Surgeon, Ninth Regiment, N. G. S. N. Y. ; late Attending Surgeon to Bellevue Hospital Dispensary, New York. Fourth edition, revised and enlarged. New York : D. Appleton & Co. 1902.

In recent years, instruction in how to render prompt aid to the injured has been made part of the training not only of the hospital corps of the army but of many civil bodies, notably the police of our cities. This little manual is especially designed for the instruction of these non-medical persons, and it succeeds admirably in its purpose. In simple, non-technical language it furnishes an outline of anatomy and physiology, and supplements this with clear directions as to the use of bandages, slings, compresses, tampons, etc., and the treatment of wounds, fractures, burns, coma, asphyxia, drowning, poisoning, and other emergencies. The chapter on disinfection has been entirely rewritten, in order that it may be in harmony with the results obtained by recent scientific investigation. The book is fairly well illustrated, and will undoubtedly retain its position at the head of such works.

A Compend of Special Pathology. By Alfred Edward Thayer, M.D., Assistant Instructor in Gross Pathology, Cornell Medical College. Formerly Fellow in Pathology, Johns Hopkins University ; Instructor in Anatomy, Yale Medical College ; and Professor of Bacteriology, West Virginia University. Containing 34 illustrations. Philadelphia : P. Blakiston's Son & Co. 1902. Price, 80 cents, net.

The present work, a companion to the author's compend of General Pathology, shares the merits and the failings of the latter. Its failings are simply those of any book which endeavors to present in limited space the essential facts of a tremendous subject ; but such books must continue to exist, and if used simply to refresh the memory after a study of the more complete works, they have sufficient *raison d'être*. The merits of this particular compend are numerous. It succeeds, in spite of its small size, in covering a wide field ; it is thoroughly up-to-date ; and its author is enough of an analyst to have succeeded in furnishing an outline easily filled in with detailed knowledge. The illustrations, though few in number, are well-chosen. While the book will, no doubt, enjoy its greatest popularity with under-graduate students, more than one practitioner might profit by carrying it about in his pocket and reading it in his spare moments.

The Roller Bandage. By William Barton Hopkins, M.D., Surgeon to the Pennsylvania Hospital and to the Orthopædic Hospital and Infirmary for Nervous Diseases. With illustrations. Fifth edition, revised. Philadelphia: J. B. Lippincott Co. 1902.

Inasmuch as the application of the roller bandage constitutes the most fundamental of all surgical procedures, the long-continued popularity of this little book is easily accounted for. The destruction by fire of the plates and electro-types of the former edition has led to the complete remodelling of the book, and the preparation of new illustrations, which will enable it, better than ever, to teach the student the principles of bandaging.

Massage and the Original Swedish Movements. Their Application to Various Diseases of the Body. Lectures before the Training Schools for Nurses connected with the Hospital of the University of Pennsylvania, German Hospital, Woman's Hospital, Philadelphia Lying-in Charity Hospital, the Philadelphia Polyclinic and College for Graduates in Medicine, and the Kensington Hospital for Women of Philadelphia. By Kurre W. Ostrom, from the Royal University of Upsala, Sweden. Fifth edition, revised and enlarged, with 115 illustrations. Philadelphia: P. Blakiston's Son & Co. 1902. Price, \$1.00, net.

The tendency of modern therapists to rely upon physiological methods rather than drug-giving is in no way better illustrated than by the well-nigh universal employment of massage. The time has gone by when any nurse could be considered "trained," and yet be ignorant of the art of physical manipulation. A small book, giving specific directions as to the methods to be employed is, therefore, a necessity; and how well this practical little work has supplied the need is shown by the issue of five editions in but little more than a decade. The present issue has been thoroughly revised, in the light of recent methods, and will, no doubt, be received with the same favor which has distinguished its predecessors.

"**Russian Ramblers**," by I. Hapgood, contains the following statement: "Very few Russians wear anything but linen underwear, and foreigners who have been accustomed to wear flannels are forced to abandon them in Russia." The climate of Russia is known for its severity. Experience has taught the Russians that flannels weaken the skin and put those who wear them in constant danger of colds and pneumonia; hence, they clothe themselves in safer and more trustworthy linen underwear. The Dr. Deimel Trade Mark on Linen-Mesh Underwear is equal to the "Sterling" mark on silver.

Substitutors Steal Physicians' Patients. Incidentally, the Antikamnia Chemical Company is after "Counterfeiters" and "Substitutors" with a sharp stick. Their work in New York City is, no doubt, well known to our readers and they have now broken up a counterfeiting gang in New Orleans.

There cannot be two views on the subject of substitution. It is swindling, pure and simple. In other words, the doctor's patient is taken out of the doctor's hands, transferred absolutely to the substitutor's care and then given whatever remedy the substitutor thinks best. All this, irrespective of the doctor's diagnosis. In short, the treatment is in accordance with the "diagnosis" made by the substitutor. And as all substitutors are thoroughly saturated with avarice, greed and utter disregard of the most sacred rights of others, the fate of their victim can well be imagined. It is the purpose of The Antikamnia Chemical Company to expose and punish this crime wherever they locate it, and they have notified the trade that the least punishment "Substitutors" of this kind can expect, is exposure of their guilt.

This Denver physician's experience is the same as a good many others.

"A child, thirteen months old, teething, had for some time suffered with a very watery, greenish diarrhœa, bowels full, hot and gurgling continually, head rolling, eyes half closed in sleep, hands and feet cold, and frequent straining to vomit. Could retain no food, either mother's or fresh cow's milk, pulse 120, feeble, head bathed in cold perspiration, bowels evacuated twelve to eighteen times in twenty-four hours. I began using Eskay's Albumenized Food in teaspoonful doses hourly : it was retained and amount increased until about second day, when about half meals were given every three hours. I had no more vomiting. The child is now well and in excellent health and flesh."

Blood for Babies.—In the course of the second year there comes a time when the milk diet begins to be insufficient for the growing child, and Nature calls for a change, while yet the system is in many cases unprepared for solid food. This kind of deadlock results in diarrhœa or constipation, anæmia, restlessness, fretfulness, etc. In such cases the fit and radical remedy will be found in the administration of say ten drops of bovine in a little milk, at intervals of three hours.

Little Robert Valverdie, a patient who came under my care in the condition of malnutrition above described (after trying all the usual medical helps with no benefit), was immediately restored by the direct blood treatment. On the second day of taking bovine, the constipation and other trouble began to be relieved, and on the third day all signs of ill health disappeared as if by magic. This simple treatment was continued for three weeks, the child thriving beautifully.—Case reported by Dr. T. J. Biggs.

Removals.—Dr. A. J. Moore, of Brunswick, Mo., to 1023 Nineteenth avenue, Denver, Col.

Dr. F. E. Bamberger, 1533 Vine street to Children's Hospital, Franklin and Jefferson streets.

Dr. H. G. Carmalt, H. M. C., 1902, has located at Indiana, Pa.

Dr. W. H. Newmuller, H. M. C., 1902, to Metropolitan Hospital, New York.

Dr. W. H. Bailey, Chile Station, N. Y., to Savannah Mo.

The Homœopathic Practitioners' Association of Reading.—The midsummer meeting of the Homœopathic Practitioners' Association of Reading, Penna., was held at Woodvale Inn on July 30th, 1902, and called forth a large attendance of physicians from Reading and adjacent towns and cities. After calling the meeting to order, the president, Dr. Lewis A. Schollenberger, referred with deep feeling to the death of Dr. F. R. Schmucker, of Reading ; and eulogies on his life by Dr. W. C. Powell, of Bryn Mawr, and Dr. F. E. Howell, of Reading, followed. Papers were read by Dr. F. Mortimer Lawrence, of Philadelphia, on "The Modern Treatment of Pulmonary Tuberculosis" (see page 676), and by Dr. W. F. Marks, of Reading, on "Hemorrhages from the Mucous Membranes." The papers elicited an active discussion, after which the meeting adjourned to the dinner table. Later on a number of the visitors enjoyed a trip by gravity road to the summit of Mt. Penn.

Among those who attended the meeting were Drs. William S. Kistler and J. S. Kestler, of Shenandoah ; Drs. L. T. Ashcraft, I. B. Gilbert, E. M. Gramm, N. F. Lane, F. M. Lawrence, W. A. D. Pierce, C. S. Raue, and W. H. Tomlinson, of Philadelphia ; Drs. L. P. Maddux, G. C. Webster, Isaac Crowther, and C. W. Perkins, of Chester ; Drs. E. B. Rossiter, C. A. Yocum, and A. C. Shute, of Pottstown ; Dr. A. P. Seligman, of Mahanoy City ; Dr. William Kistler, of Minersville ; Dr. C. F. Shinn, of Norristown ; Dr. W. C. Powell, of Bryn

Mawr; Dr. S. G. Godshall, of Edge Hill; Dr. George I. Baier, of Norwood; Dr. E. L. Clarke, of Media; Dr. H. G. Wiest, of Schuylkill Haven; Dr. Burt G. Arnold, of Downingtown; Drs. W. D. Garvin and D. W. Straub, of Bethlehem; and Drs. C. M. Richards, F. E. Howell, W. F. Marks, I. E. Harner, C. R. Haman, D. C. Kline, H. F. Schautz, F. W. Seidel, J. S. Rittenhouse, G. I. Keen, W. A. Haman, S. L. Dreibellis, and L. A. Schollenberger, of Reading. The presence of the wives and daughters of several of the party added a pleasant social feature to the occasion.

A Homœopath Honored.—At the last semi-annual meeting of the State Board of Medical Examiners, of Washington, the annual election of officers occurred and resulted as follows: Dr. C. E. Grove, Spokane, *President*; Dr. W. C. Cox, Everett, *Vice President*; Dr. P. B. Swearingen, Tacoma, *Secretary*; Dr. J. H. Hoxsey, Spangle, *Treasurer*. The board is composed of seven allopaths, one eclectic, and one homœopath. Dr. Grove, who is a graduate of Hahnemann (Phila.), 1889, is the only homœopath on the board. Eighty-four applicants were examined by the board, five of whom were homœopaths. Two were women.

New York State Homœopathic Medical Society.—The thirty-sixth semi-annual meeting of the New York State Homœopathic Medical Society will convene in Utica on Tuesday and Wednesday, Sept. 16th and 17th. The sessions will be held in the auditorium of the New Century Club, and the first floor of the building will be given over exclusively to exhibitors. On Tuesday evening a banquet will be held in the banquet hall of the Masonic Temple. General Terry will act as Toastmaster, and a number of bright speakers have been secured. Excellent hotel accommodations can be secured at reasonable rates.

Personals.—Dr. J. R. Gillette has removed to 1801 N. 15th St.

Dr. R. T. Wiltbank, after a short sojourn in California, has returned and located at 505 Tasker St.

The Hahnemann Hospital College of San Francisco has removed to new quarters—406 Sutter St.

The Denver *Journal of Homœopathy* has removed to 230 Majestic Building, Denver.

Dr. Henry E. Porter, Hahnemann, 1902, has located at Coatesville, Pa.

Dr. George R. Southwick, of Boston, is spending two months in the European hospitals, paying particular attention to the use of the X-ray and other forms of light therapy.

Drs. F. Mortimer Lawrence, C. Sigmund Raue and W. H. Lyle have been spending some time in the medical institutions of Boston, Mass.

Its Distinctive Feature.—One needs but to review the physiological activities of the remedies recommended as tonics and reconstructives to realize the fact that practically all of them have some secondary effects which detract from their clinical value. It may be that they irritate the stomach and thereby excite repulsion on the part of the patient, or even induce nausea and vomiting; some of them are astringent, others primarily stimulating but secondarily depressing—and so on through the entire category of remedies, objections more or less serious may be found. It is, therefore, a matter of great importance to employ a remedy which is not only free from deleterious by- and after-effects, but which adapts itself to use as a routine remedy in the many and diverse conditions that call for tonic and reconstructive medication.

The one remedy which many years of experience proves is entirely free from detrimental effects is Gray's Glycerine Tonic. This preparation is of pleasant

taste, agrees perfectly with rebellious and sensitive stomachs, patients never tire of its continued administration, and it is extremely effective in restoring tone and vigor to the entire system.

The entire freedom of Gray's Tonic from anything like drug effects is one of the strongest reasons why the best element of the medical profession have adopted the remedy for routine administration in all conditions associated with impairment of general health, lack of nervous energy, general exhaustion—in anæmia, malnutrition, neurasthenia, and in chronic wasting diseases.

The Best Method of Modifying Cow's Milk.—A prominent New England physician states that, "For the past twenty years it has been my habit, in infant feeding, to use one part cream to seven of sterilized water, adding sugar of milk q. s. to taste; this was by far superior to anything I could obtain until I began using Eskay's Albumenized Food, which, added to cow's milk, obviates the necessity of extemporizing as formerly. I have never seen children thrive better than when feeding was restricted to Eskay's Food alone. Nothing more seemed to be required."

Treatment of Pre-Senility.—Fergusson details a case of impotence following a prolonged attack of gonorrhœa. It was his third attack, and his virile power was almost lost, and he suffered from frequent micturition. He had, in addition, orchitis on both sides. The case was peculiarly obstinate, and many remedies had been used to no purpose. He had already exhausted the resources of several quacks. Sanmetto was prescribed in teaspoonful doses three times a day, and improvement and recovery followed.—*Medical News*.

Celerina is a powerful stimulant without the depressing after-effects of alcohol, caffeine, nitro-glycerine, etc. It is also a reliable Nerve Tonic. A pleasant exhilaration is experienced after a dose of one or more teaspoonfuls, and under its continued use a renewed capacity for physical and mental exertion results. It is indicated in all forms of exhaustion, mental inertia, and senile weakness.

British Homœopathic Association.—This Association has been formed for the extension and development of homœopathy in Great Britain. It is desired to enlist the personal co-operation of homœopaths throughout the kingdom in this timely movement. The officers are as follows: *President*, the Earl Cawdor; *Vice-Presidents*, the Earl of Dysart, the Lord Calthorpe; *Trustees*, Joseph Howard, Esq., M.P.; J. P. Stillwell, Esq., J. P.; Wm. Willett, Esq. *Treasurer*, Joseph Howard, Esq., M.P.; *Vice-Chairman of Executive Committee*, Henry Mansfield, Esq., J. P.; *Secretary*, Mr. Fredk. King, 29 Monument Street, E. C.

Hitherto no national organization has existed for the furtherance of national requirements in the extension of British homœopathy, or for keeping pace with the increasing modern necessities for the development of homœopathic science and art. At present the number of homœopathic medical men in Great Britain is far below the demand. This factor is the most serious in the existing situation. Next, there is yet no medical school or college, or examining body, for the systematic training of medical men in the practice of homœopathy. This want it is which is largely responsible for the just-named deficiency. Connected with these needs is the absence of an academic foundation or specified endowment for the further prosecution of original research, more especially in new drugs after the homœopathic method of "proving." And as the diffusion of homœopathy throughout the kingdom is largely dependent on the further establishment of cottage hospitals, it is required to

give some official impetus and encouragement to the foundation of such institutions in new centres, as well as to aid in the continuous development of the larger hospitals. To meet the pressing necessities of British homœopathy is the prime object of the Association. The work is a national work, and national aid is therefore sought. The three following methods have been decided on in order to attain the ends of the Association :

I. The British Homœopathic Association invites the individual co-operation of all who are interested in the movement, by enrollment as members or as associates. The annual subscription for members is a guinea; it entitles to the receipt of the Journal of the Association, to inclusion in the published list of members, and to the usual voting powers. The associates' subscription is half a guinea per annum; and enrollment is acknowledged in the Journal of the Association. A subscription of ten guineas confers permanent membership; and one of five guineas a permanent associateship.

Intimations of desire for membership or associateship will be cordially received by any homœopathic practitioner, or may be made direct to the Secretary of the Association.

II. For the permanent endowment of the work, a "Twentieth Century Fund" of at least £10,000 has been inaugurated by the Association. All donations over £25 are invested. Benefactors endowing in full a lectureship, or traveling or research scholarship, or any other definite part of the work, have the right to a seat on the governing body, as well as to have the donor's name permanently incorporated in the title of the endowment. The donation of a capital sum for endowment may, at the benefactor's option, be spread over a period of three years.

III. A Central Ladies' Committee has been appointed to co-operate with the Executive Committee in the work of the Association. This Central Committee has decided, in the first instance, to collect by December, 1904, the necessary funds (£1500) for the permanent endowment of a scholarship in homœopathy. The London Centre is desirous of establishing local branches over the kingdom to work conjointly to the same end. Material progress has already been made in the necessary arrangements. The secretary of the Central Ladies' Committee is Mrs. Henry Wood, 34 Clanricarde Gardens, Hyde Park, W., who will be happy to communicate directly with any ladies who may be able to organize local branches, or otherwise aid in this work.

It is hoped that every friend of homœopathy throughout the kingdom will be personally associated with one or other of these alternative methods of aid. The time for assistance is the present time.—*Bis dat qui cito dat*. It is of prime importance to support this active movement, and to take every advantage of the present wave of enthusiasm, in order to accomplish the object in view. Subscriptions and donations will be received at once and acknowledged by the secretary, Mr. Fredk. King, 29 Monument Street, E. C.

The J. Lewis Crozer Homœopathic Hospital of Chester, Pa.—The corner-stone for the Homœopathic Hospital endowed by the late J. Lewis Crozer was laid July 17th with appropriate exercises. The new hospital is within a short distance of the J. Lewis Crozer Home for Incurables, which was founded by the man after whom it was named. The exercises were attended by quite a large concourse of people, including prominent medical personages from Philadelphia and other counties, local society people, and persons interested in charitable work.

A more pleasant day for the laying of the corner-stone could not be desired. The Home and the new hospital stand upon the crest of a hill, and the breezes which swept the summit were delightful.

The invocation was by the Rev. Frank C. Woods, pastor of the Upland Baptist Church. He called upon Almighty God to bless the work which was about to be consummated and the goodness of the man who had provided for such an institution.

The object of the gathering was stated by the Rev. Francis M. Taitt, rector of St. Paul's. He said that the laying of the corner-stone marked the completion of another step toward the consummation of the magnanimous charity provided for by the late Lewis J. Crozer. The stewardship of wealth was an important office, and but few wealthy persons have discharged their duties of stewardship as ably, as charitably and with such provisions for the afflicted poor as J. Lewis Crozer.

Dean Taitt also referred to the excellent manner in which the widow of the man who provided for the Home for Incurables and the Hospital was carrying out his desires, and exerting every effort to bring to successful ends his arrangements and provisions.

The laying of the corner-stone followed this address. The stone was laid by Mrs. Crozer, the widow of J. Lewis Crozer.

Rector Taitt then said: "In the name of God, and for the benefit of suffering humanity, the corner-stone of the J. Lewis Crozer Homœopathic Hospital is now laid." A short prayer was then said by Dean Taitt, and the exercises closed with the singing of the doxology by the entire gathering.

J. Lewis Crozer Hospital is to be built of granite, darker in color than the Home, which is only a short distance away. The central portion of the first floor, opposite the main entrance, will be used as an operating room, and the west wing will be the medical wards for men and women. In the basement will be the dispensary and the receiving-room for emergency cases. The building will also have a number of private wards. The third story of the Home for Incurables, which is not used at present, will be turned into dormitories for nurses. A training-school will also be established, and nothing will be left undone which will tend to make the combined institutions as modern as any in the country.

The late J. Lewis Crozer provided in his will for the erection of a Home for Incurables and a Homœopathic Hospital, endowing these institutions with \$500,000. After his death, his widow proceeded to carry out the plans of her husband, but has not touched a cent of the original endowment. Out of her own fortune she purchased the thirty-six acres of land on which the institutions stand; the Home has been erected, and has been maintained for several years; the hospital is now being built, and the original endowment of one-half of a million of dollars still remains intact, and has been accruing interest all the time.

As the cost of the purchase of the land and the erection of the buildings has not in the least affected the amount of the endowment, the sum as it now stands is believed to be amply sufficient to operate these noble charities for all time.

The A. R. Thomas Medical Club.—The members of the A. R. Thomas Medical Club were entertained by Dr. W. W. Speakman at "The Hemlocks," his new summer home, near Buck Hill Falls, Cresca, Pa., on June 27, 1902.

The day was given up to golf, tennis, trap-shooting and fishing, and a very enjoyable informal dance in the evening closed a day that will long be remembered.

Resolutions on Death of Dr. Wm. Tod Helmuth.—At a meeting of the Westchester County Homœopathic Medical Society, held in Mount Vernon, N. Y., on Wednesday, May 28th, the following was adopted by the

society, copies ordered to be sent to his family, placed upon the minutes, and printed in the **HAHNEMANNIAN MONTHLY**.

DR. WILLIAM TOD HELMUTH.

The members of the Westchester County Homœopathic Medical Society, each sharing the universal sorrow of the profession throughout the civilized world, and to most of whom the name of Dr. Helmuth awakens sweetest reminiscences of college days, in which his charming personality seems to have been always foremost, desire to place on record our high appreciation of his distinguished ability, his matchless career and his unique illustrious individuality, his devotion to the homœopathic medical profession and to surgery in particular, to medical education and to each and every medical student, to medical literature and journalism; in fact, to everything that appertained to the best and highest interests of that which was noblest in our profession.

His brilliancy, ever radiant, as scholar, lecturer, orator, poet, was equalled, if not outdone, only by the gentleness and sympathy of his nature as physician, surgeon, counsellor and friend.

We sit with heads bowed down, deeply mourning our unspeakable and irreparable loss, begging to extend to his sorrowing family our heartfelt sympathy, assuring them that as long as we live the name of Dr. Helmuth will awaken in our grateful hearts the profoundest memories and associations.

“We ne’er shall see his like again.”

“Malaria” and Tonics.—Malaria is a much-abused term. It has been used to cover every vague illness with which the physician has to contend; and even in spite of the modern scientist, who insistently proclaims that malaria is an infective disease as definite in its symptomatology as typhoid itself, more than one of the older practitioners will continue to pacify his diagnosis-seeking patients with a word—“malaria”—and a tonic. Vague though the latter term may be, it represents a distinct popular want; and it is worthy of note that the three remedies most useful in malaria, viz., iron, arsenic and quinine, are also the best of the so-called tonics. Recently Messrs. Schieffelin & Co., of New York, have introduced, under the name of Hemoquinine, a combination of arsenic and quinine with the peptonate of iron, the preparation representing an association of these drugs which insures to the fullest extent their therapeutic properties, and which will be tolerated by the most sensitive digestive organs. In cases of chronic ill health, whether malarial or otherwise, such a remedy can scarcely fail to benefit the patient.

Medical Legislation Needed.

Hahnemannin Monthly

Dear Sir

I would like to have sampl No of your journalls with terms of subscription for 1902. Would you please tell me how the socalled water doctors diagnose all cases of sickness by looking at a little vile of the patients urine? What? do they put in it? How? do they tell?

Respectfully yours.

Dr _____

It is a fact worthy of record that during the year 1901 there were imported into the United States 120,359 cases of G. H. Mumm’s Extra Dry, or nearly 60,000 cases more than any other brand. This is certainly a banner performance, and but goes to show how much appreciated the good qualities of Mumm’s are in this country. It is certainly a beautiful wine, and well suited for use by the sick.—*Canadian Journal of Medicine and Surgery*, March, 1902.

THE HAHNEMANNIAN MONTHLY.

OCTOBER, 1902.

A BRIEF RESUME OF RECENT AND IMPROVED METHODS IN THE TREATMENT OF GENITO-URINARY DISEASES.

BY L. T. ASHCRAFT, A.M., M.D.

(Chairman's Address, Bureau of Surgery, Homœopathic Medical Society, State of Pennsylvania, Philadelphia, September 23, 24 and 25, 1902.)

Mr. President, and Members of this Society :

Truly, he who devotes his career to the practice of genito-urinary surgery may say, with pardonable pride, we have accomplished much. Lest such a statement be challenged, defensively we say that we have given to the profession both men and things. Men like Hunter, Thompson, Moullin, Harrison, Guyon, Albarran, Janet, Fournier, Ultzmann, Finger, Goldberg, Josephs, Caspar, Woosidlo, Oberlander, Kollmann, Bottini, Freudenberg, and in this country Otis, Keyes, Taylor, Valentine, Alexander, Fuller, Guiteras, Lydston, Bransford-Lewis, Bellfield, and a host of others whose industry and brains have succeeded in placing the treatment of genito-urinary diseases upon a clearly scientific basis.

They have invaded the kidneys, placed the pathology of bladder and prostatic diseases upon a firm basis, pointed out the relationship of the latter to sexual neurosis and perfected operative measures for the removal of its overgrowths, established in the lay mind the conviction that syphilis is a curable and a very manageable disease, at the same time demonstrating the disastrous and far-reaching results of an uncured gon-

orrhœal urethritis. In addition thereto, the skilled mechanic, prompted by their suggestions, has perfected instruments which, when guided by a steady hand and an intelligent eye, transform what seems like a puzzle to a problem easily solved.

Kidney.—Perhaps the most noticeable achievement is Edebohl's treatment of chronic Bright's disease by operation.*

The operation, which is termed nephrocapsasectomy, consists in dividing the capsule along the entire length of the convex external border of the kidney and clean around the extremity of either pole. Each half of the capsule proper is in its turn stripped until the entire surface of the kidney is denuded; the stripped-off capsule is cut away close to its junction with the pelvis of the kidney. Both kidneys may be operated upon at one sitting. A cure or amelioration is brought about by arterial hyperæmization of the kidney, obtained both from the denuded organ and its fatty capsule. The increased and adequately maintained blood-supply thus established leads, most probably, to gradual absorption of the interstitial or intertubular inflammatory products and exudates, thus freeing the tubules and glomeruli from external compression, constriction, and distortion, and permitting the re-establishment in them of a normal circulation. The result of this is the regenerative production of new epithelium capable of carrying on the secretory function.

Of eighteen cases operated, three disappeared from observation; of nine so treated a year ago one was not benefited; of four operated upon six months ago two were permanently cured. Two have been quite recently subjected to this method.

In deciding for decortication it must be remembered that renal decapsulation is not directly and forthwith curative of chronic Bright's disease, but that it only leads to a cure or improvement by establishing circulatory conditions essential to such. The attainment of a permanent cure or the full measure of improvement possible in a given case will necessarily require them.

Cystitis.—Eastman† advocated practicing permanent catheterization for chronic cystitis. In fifteen cases the catheter was retained for from ten to sixty days. No irritability, acute cys-

* Reprint from the "Medical Record," December 21, 1901.

† "Journal American Medical Association," November 9, 1901.

titis, or other complications arose. The urine is drained into a receptacle immediately upon entering the bladder. It is a method of choice in selected cases, because by its use the urine is removed by its natural exit; it likewise melts urethral deposits, thereby increasing the lumen of the canal. If used after perineal section for stricture, subsequent sounding becomes unnecessary, as the new segment of urethra has a guide over which to form itself. The writer claims that this method likewise minimizes the danger of bacterial or uræmic poison, and may obviate the necessity of a suprapubic or perineal cystotomy. In connection with this subject, I wish to emphasize the value of cystoscopy, since by such means we can thoroughly view every portion of the bladder-walls, examine the sphincter to see whether it be normal or hypertrophied or otherwise inflamed, detect calculi in the pouches behind the trigone, inspect ulcers, and both locate and examine the ureters. Especially is this of importance in determining the location of lesions which may be responsible for vesical hyperæsthesia or chronic cystitis. So expert have cystoscopists become that with an operating instrument much can be done intravesically, such as crushing calculi, curetting ulcers, and cauterizing bleeding-points. The refinement of cystoscopy is ureteral catheterization, which, with perfected technique, is devoid of danger. Everyone will agree with me that it far outweighs efforts at obtaining urine by the segregator of Harris.

The instrument which I use is the improved Bellfield cystoscope. It possesses many good features, since it can be sterilized by boiling, and it is exceedingly light and simple in its construction. Also, direct vision may be obtained by a cold lamp, thus avoiding a cumbersome cooling apparatus. Again, as with this instrument the bladder may be distended with air, we are enabled to make direct applications to its walls and to catheterize the ureters under direct vision. In order to perform cystoscopy, the bladder must have a capacity of three ounces. The urethral calibre must be equivalent to twenty-four French; also, there must not exist a too-marked hypertrophy of the median lobe of the prostate. Naturally, the bladder must be cleansed, after first having been emptied, preferably by irrigation with boric acid; otherwise vision is obscured. General anæsthesia is desirable, otherwise considerable pain

will be experienced. The thighs should be markedly flexed, thus allowing any residual urine to gravitate to the fundus; the operator is then not annoyed by urine trickling through the instrument and obscuring vision. In this position the ureters are readily catheterized by elevating the instrument only slightly.

Incontinence of Urine.—Albarran and Cathelin* have recently treated fifteen cases of incontinence of urine by epidural injections of serum, using fifteen to twenty cubic centimetres to an injection, or of cocaine two per cent., using one cubic centimetre to an injection. Usually, two or three injections were given every other day. All of the cases were materially improved; some were cured. Complete failure occurred in two cases of urinary tuberculosis.

Hypertrophy of the Prostate.—Hypertrophy of the prostate is of such paramount importance that it may be interesting to review certain points concerning it. A discussion of its prophylactic treatment naturally leads to the removal of factors, such as obstructive and inflammatory conditions, which play an important rôle in its production. Treatment should be especially directed towards congestion of the prostatic urethra by instillations, topical applications through the urethroscope, the judicious use of both sounds and dilators, and by the psychrophore. Where chronic prostatitis exists, I would divulse the sphincter ani, massage the prostate, and perhaps use electricity. If the condition develops into a true enlargement, in order to obtain relief it is necessary to resort to a choice of either catheter-life or a radical operative procedure. Let us inquire into their respective merits: Catheter-life is but a palliative procedure, which, after three or four years, is usually supplemented by an operation, although we are all acquainted with elderly men who seem to go comfortably through it; but constant use, even with aseptic precautions, usually produces cystitis, epididymitis, and perhaps ascending infection. Recognizing, then, its dangers, would it not be advisable to operate immediately after the diagnosis is made, instead of waiting, as most surgeons do, until the bladder and kidneys are impaired? I believe it advisable, and so expressed myself two years ago.†

* "Annales des Mal. d. Org. Genito-Urin."

† "The Proper Time and Methods of Operating for Hypertrophy of the Prostate." Read before the Homœopathic Medical Society of Delaware County September 13, 1901.

Having decided to operate, what method shall we employ? One hears very little, these days, concerning either vasectomy or castration. Horwitz, in a recent article,* says that castration is indicated in chronic congestion of the organ where the glandular element predominates. Bottini's operation should be done as a prophylactic measure, when the diagnosis is made in the incipency of its overgrowth, irrespective of the character of the enlargement; such will eliminate the consequences of catheter-life. What, then, are the indications for the employment of this operation as a radical procedure? Some denounce it entirely, and fail to recognize any virtue whatever in it,—notably Fuller, Keyes and Alexander; again, there are others who think it suitable to every case. That both are wrong will be proven by quoting those who have most frequently made it, as Bottini, Freudenberg, Meyer, Horwitz, Young, Chetwood and myself. It is distinctly indicated where a middle lobe, bar, or some well-recognized impediment, exists: likewise when there is a moderately regular fibrous enlargement of the lateral lobes. It may, too, be practiced on those who, because of old age and a diseased condition of the kidneys, are unsuited for other operative measures.

The contra-indications are distortion of the prostatic urethra, ball-valve predominance of the middle lobe, enormous and distended overgrowths which encroach greatly upon the bladder-space, and an atheromatous condition of the arteries, together with a pouching of the bladder. Where there is a marked degree of cystitis, I combine it with a perineal cystotomy, the advantages of which have been previously summarized.† Finally, what are the results of Bottini's operations? Quoting an article by Freudenberg:‡ “In seven hundred and fifty-three cases there was a mortality of 4.25 per cent. to 5.48 per cent.—7.66 per cent. failures, 86.63 per cent. good results; among two hundred and forty-eight good results, 61.29 per cent. were cured, 38.71 per cent. greatly improved.” Cures were those

* “What I Have Learned from 161 Operations for the Relief of Senile Hypertrophy of the Prostate.”

† “The Bottini Operation for Hypertrophy of the Prostate; A Modification of the Technic.” Reprint from the “Transactions of the Surgical and Gynecological Association of the American Institute of Homœopathy,” June, 1900.

‡ “Electricity in Medicine and Surgery,” King.

who could micturate without the use of the catheter, and where the residual urine had either entirely disappeared or had diminished to an insignificantly small quantity. Other noticeable symptoms, such as improvement in appetite, cure of constipation, and gain in weight, were evident. What are the indications for prostatectomy? and what route shall we select? It is the operation of choice when there is a decided median or ball-valve obstruction; when there is a hard and irregular fibrous enlargement of all lobes; also when irregular phases of development encroach upon and distort the prostatic urethra projecting into the bladder. Under such circumstances enucleation is advisable; but the operation should not be attempted in those who are over sixty-five years of age, and then only when the kidneys are healthy, and the bladder fairly so. What route shall we elect for enucleation? Chetwood, in an article,* gives the views of sixteen operators. The suprapubic operation bears the endorsement of Fuller, Lillienthal, Wishard, Buxton Browne and Freyer. Two of these men, however, combine it with perineal drainage. Murphy† says that "Suprapubic prostatectomy should be limited to exceptional cases of intravesical enormous enlargement of the prostate." M. Albarran says:‡ "It is a grave operation, with an average mortality of 20 per cent., and that in many cases operated on suprapubically, after the temporary improvement the symptoms returned." The perineal route is favored by Watson, Guiteras, Ferguson, Parker, Syms, Bryson, Tuffier, Deaver and Albarran. The indications for its employment, according to Bransford-Lewis,§ are general hypertrophy of all lobes without intravesical projections, excessive development of the prostate in the direction of the rectum, large or very thick bar-formations, with marked compression of the urethra between the enlarged lateral lobes. The mortality is about 6 per cent. The conclusions are that both vasectomy and castration are seldom practiced, a choice of operation lying between prostatomy and prostatectomy, the former being safer and having a wider

* "Surgical Treatment of Prostatic Hypertrophy."

† "Journal of American Medical Association," March 22, 1901.

‡ "Société de Chirurgie," November, 1901.

§ Discussion of the Operative Treatment of Prostatic Hypertrophy, "Journal of Cutaneous and Genito-Urinary Diseases," July, 1902.

range of applicability. It, however, occasionally has to be repeated, but is usually the operation of election, many combining it with perineal drainage. Prostatectomy is more radical and more successful in its ultimate results, but has a higher mortality rate. Opinion favors the perineal route, when accessible.

Prostatitis.—While there is nothing new to offer concerning the treatment of either acute or chronic prostatitis, or seminal vesiculitis of gonorrhœal origin, yet it might not be amiss to mention some of the salient features previously outlined in my former articles.* Chronic gonorrhœal prostatitis and chronic gonorrhœal vesiculitis are usually co-existent, and frequently we find an associated inflammation of the posterior urethra and the epididymis; likewise, chronic inflammatory changes in these organs are regarded as largely responsible for sexual neurasthenia. Again, about 90 per cent. of chronic gonorrhœas are here localized; consequently, their eradication becomes necessary. With this end in view, in addition to the well-recognized methods of treatment, I wish to again particularly emphasize the value of massage of both the prostate and the seminal vesicles in chronic inflammatory conditions. So effective is this method that it is impossible to imagine recovery without its employment. Recently I have employed the galvanic current, which appears to decongest both the prostate and vesicles.

Epididymitis.—Brin† recently advocated treating gonorrhœa complicated by orchitis with irrigations, and claims excellent results, the testicle becoming painless in three days. Valentine‡ endorses it. About a year ago, my clinical associates treated a number of such cases with instillations of nitrate of silver, using a 1 per cent. solution in the posterior urethra, repeating it every other day. We found that in conjunction with scrotal support it quickly reduced the epididymitis. As

* "The Diagnosis and Treatment of Acute Gonorrhœal Prostatitis," Transactions of the Homœopathic Medical Society, State of Pennsylvania, 1900. "The Diagnosis and Treatment of Chronic Gonorrhœal Prostatitis," HAHNEMANNIAN MONTHLY, October, 1902. "Seminal Vesiculitis," HAHNEMANNIAN MONTHLY, April, 1898.

† French Society of Genito-Urinary Surgery, "Journal of Cutaneous and Genito-Urinary Diseases," March, 1902.

‡ "The Irrigation Treatment of Gonorrhœa."

a routine method, however, I prefer to discontinue local treatment and give a well-selected remedy. A number of years ago, Dr. Van Lennep advised me to practice perineal drainage in those cases of chronic epididymitis which showed a tendency to acute outbreaks apparently without much exciting cause. Since adopting it, I have obtained excellent results. This procedure is beneficial, since it affords an opportunity for drainage.

Urethritis.—Reviewing urethritis, James C. Johnson* presents a new classification of non-gonorrhœal urethritis, in which he describes a pseudo-gonococcic or catarrhal urethritis, the distinctive features of which are those of a recurrent gonorrhœa, namely, a longer period of incubation, very few annoying symptoms, and a tendency to become quiescent without treatment. The condition, while temporarily mild, frequently recurs. The organism which is present is rounded, occurs in pairs, is usually extra-cellular, and decolorizes with Gramm methods, but grows on ordinary media and serum-agar. A uric acid urethritis: There is considerable distress and discharge associated with this form. I have seen a number of these, and have succeeded in removing them by a suitable dietary and well-selected remedies: A streptococcic type, of which he is somewhat skeptical; a staphylococcic variety, which is quite mild; a toxic, in which the infection arises from the prostate, bladder, or kidneys, the features of which are a purulent, intermittent discharge, free from organisms, and not painful.

New injections claiming to abort gonorrhœal urethritis are very popular. Recently I have experimented with albargin, or gelatose silver. It contains 15 per cent. of silver, and rivals nitrate of silver and the other silver combinations, such as protargol and largin, as an antigonorrhœic, since it possesses all their virtues minus their irritating properties. Without any difficulty, a 10 per cent. standard solution can be made with distilled water, from which, by means of a graduated cylinder, the necessary quantities can be taken for dilutions, which can be made with ordinary hydrant-water. It is usually used in a 0.2 per cent. solution, but in strong inflammatory condi-

* "Journal of Cutaneous and Genito-Urinary Diseases," Sept., 1902. Transactions of the N. Y. Academy of Medicine, Section on Genito-Urinary Surgery.

tions is injected in a 0.1 per cent. or 0.15 per cent. solution, the patient making four or five injections daily in the beginning. Later, these injections are combined with some astringent. Where the inflammatory conditions are not great, it should be combined with the irrigation treatment. It kills the gonococci as far as it can reach them without causing any complications, on an average, in about twelve days. We usually hold the solution in the canal five minutes at each sitting,—discontinuing it, after the appearance of the gonococci, in favor of the irrigation method. It should be used only on those who are in their first attack. This preparation bears the endorsement of Max Josephs, who gave me the results of his experience, which I take pleasure in appending:

Number of Cases.	Permanent Disappearance of Gonococci. Number of Days.
2	1
5	2
4	3
8	4
6	5
3	6
2	7
1	8, 9, 10
3	12
8	16

The following is the result of our experience in the Genito-Urinary Clinic of the Hahnemann Hospital Dispensary:

Number of Cases.	Permanent Disappearance of Gonococci. Number of Days.
1	5
3	6
3	12
4	15
1	17
1	20
2	24

Of these, two developed posterior urethritis.

In my private practice I have had twelve cases; the results obtained are as follows:

Number of Cases.	Permanent Disappearance of Gonococci. Number of Days.
4	5
2	6
3	8
	12

No complications occurred. Recently I have been using it in chronic cases, and later hope to present my report.

In the various manifestations of chronic inflammation of either the anterior or posterior urethra, much can be done with the urethroscope. It should be used only in the declining stage of urethral inflammation, and in the various phases of the chronic type. The one which I use is known as Guiteras's urethroscope. The advantage of this instrument is a direct light at the end of the tube, furnished by a cold lamp, which is attached to the terminal end of the carrier, the latter fitting in an especial slot, thus offering no interference with direct vision, the calibre of the tube being free for the application of medicaments. Swinburne has invented a posterior urethroscope which has an attachment by which the posterior urethra may be dilated.

I have so often obtained excellent results in chronic posterior urethritis by draining the bladder through the perineum that, were it not for appearing too radical, I would more often suggest it. It is beneficial since it removes all mechanical obstructions immediately, this affording an avenue for drainage; also, by stretching the sphincter vesicæ during operation, it gives that much overworked muscle a rest. It also saves time—a desideratum.

Urethral Stricture.—There are several important points connected with the subject of urethral stricture which are worthy of mention. Quite a few claim to find strictures in the prostatic urethra. At a recent meeting of the French Society of Genito-Urinary Surgery a discussion arose concerning the value of the catheter a-demure following internal urethrotomy. H. Reynes* claimed that it is unnecessary, although the majority present attributed their good results to its presence. My views are in accord with Reynes. I wish to emphasize most forcefully the evils resulting from deep and extensive incisions while performing internal urethrotomy. Such is very reprehensible, and is entirely responsible for prolonged hemorrhage and incurvation of the penis following this operation. By cutting only the strictured areas these complications will be avoided.

* "Journal of Cutaneous and Genito-Urinary Diseases," May, 1902.

Hydrocele.—E. Doyen* describes a new method for the radical cure of hydrocele by inversion of the tunica vaginalis. Winklemann† also claims credit for it. The operation, which is made under Schleich's infiltration method, consists in exposing the tunica in the usual manner; an incision is made in the upper portion of the sac, in the vicinity of the cord, large enough to permit the testicle to be drawn through; afterwards the fluid is evacuated, when the tunica vaginalis is turned back, in order to prevent the testicle from slipping back into the sac. The upper part of the tunica vaginalis is secured by means of fine catgut to the fascia of the cord, a suture being at the same time placed at the lower end of the tunica, thereby anchoring it, thus preventing the testicle from returning to its normal position. The testicle, together with the inverted sac, is then replaced within the scrotum, and the wound closed by means of interrupted sutures. This operation is not indicated in old hydroceles. Recurrence is improbable, because the inverted tunica vaginalis must become attached to the surrounding structure, and the cavity furnished is thus permanently obliterated.

Syphilis.—In connection with the subject of syphilis, it is interesting to learn that the Justus test has by many been proven to be of no practical value in the differential diagnosis of venereal ulcers,‡ as a reaction occurs with an almost equal degree of frequency in the nonsyphilitic conditions with which syphilis may be occasionally confused. This test is based upon the theory that mercury, given either by subcutaneous or intravenous injection or by inunction, will cause a diminution in the hemoglobin of the blood. In the healthy or nonsyphilitic individual, nature rapidly replaces this loss, but in syphilitics the loss will not be immediately compensated; so that at an examination made twenty-four hours after giving the drug it will be found that a fall of from 10 to 20 per cent. in the hemoglobin has occurred.

The reaction was observed by Justus in over three hundred cases of syphilis, while negative results were obtained in a

* "Archives Provinciales de Chirurgie," tome IV.

† "Centralblatt der Chirurgie," No. 44.

‡ Value of the Justus Test, with report of cases. Reprint from the "Philadelphia Medical Journal," May 10, 1902.

large number of control cases. The reaction further occurred in all untreated cases of secondary, tertiary and congenital syphilis, and in thirteen out of fifteen cases of initial lesion with inguinal adenitis. Latent and subsiding cases did not give a characteristic reaction; neither was any effect noted when the drug was administered by the mouth.

ON THE FUTURE OF HOMŒOPATHY.

BY CONRAD WESSELHOEFT, M.D., BOSTON, MASS.

THIS very suggestive sentence occurs in Dr. Goodno's very valuable paper on "Specific Treatments," contained in the August number of the *HAHNEMANNIAN*. Connected with it, and at the end of the article, there is a plea for better statistical evidence of the actual value and possible limitations of homœopathy. As this is a subject to which the writer of the present article has given some thought and attention in the direction of reform, Dr. Goodno's impressive words may here be quoted first in order to be compared with what has already been attempted in regard to the matter. Dr. Goodno says, p. 571:

"In the past, clinical reports have dealt too much with individual cases and groups of symptoms having a defined pathological character. Strange to say, there are few reports to be found in our literature embracing any considerable number of cases of a single disease. If you were asked as to the success attending the treatment of pneumonia, from what sources would you draw your evidence? For Dr. Smith to state that he has 'never lost a case,' or for Dr. Jones to state that he thinks his mortality is about such or such a per cent., does not satisfy scientific inquiry. Had we not better be up and doing in the matter of developing statistical evidence? Personally, the writer has had a staff working for some time upon the statistics of Hahnemann Hospital of Philadelphia, and hopes soon to present considerable statistical material. I call upon all of you gentlemen who are hospital physicians to stimulate your colleagues to unite with you in the same work."

It will undoubtedly interest the readers of the *HAHNEMAN-*

NIAN to know that others have been for some time on the path pointed out so forcibly by Dr. Goodno. For this purpose, the Report of the Medical Board of the Massachusetts Homœopathic Hospital of December 31, 1897, now five years ago, may here stand in evidence :

“REPORT OF THE MEDICAL BOARD OF THE MASSACHUSETTS HOMŒOPATHIC HOSPITAL.

“It is worthy of note that the statistical value of percentages and averages, as usually stated, is relative only. In order to estimate the value of any therapeutic method, the percentages and averages of each class of disease should be computed separately. To attempt such a computation with the few diseases of each kind occurring even during a year would show no conclusive result. This could only be obtained by computing much larger numbers of each kind, extending over a period of at least ten years. A physician might have two cases of typhoid in one year and lose both cases. The death-rate in his practice would be 100 per cent. Another might have one hundred cases and lose ten of them, giving a death-rate of 10 per cent. Obviously, comparisons of that kind are misleading; therefore, in order to arrive at more correct conclusions from statistical tables, these should comprise large numbers.

“Allow us now to call your attention to our method of keeping statistical records. In order to do this, let us consider for a moment the object of keeping such records, and then let us see if they have served their purpose. Since the beginning of this hospital, case-books have been kept in which each individual case has been entered, with all its particulars. The cases were entered with all their details arranged in columns or rubrics. For this purpose it has been our custom to rule sheets of paper in fifteen columns, each column or rubric to contain an essential feature of each case, thus: Number of case; its hospital number; date of admission; name of patient; age; sex; nationality; occupation; diagnosis; days under treatment; date of discharge from the hospital; condition of patient at time of discharge; the chief remedies used; name of physician in charge; general remarks.

“The objects of these records are manifest; but it becomes more and more evident that, as we practice a special method

of therapeutics for which we claim great advantages over other methods, our statistical records have not set forth these advantages so as to enable us to compare our results as fully as is desirable with hospitals where other methods are practiced. Hence, as our hospital would miss a large portion of its object if it failed to demonstrate the superiority of homœopathic practice over other methods of giving medicine, your Medical Board came to the conclusion that it was exceedingly *necessary to improve our system of statistical interrogation of nature.*

"This has been done by adding four more columns or rubrics to those hitherto in use, which are intended to answer the questions: *How much can homœopathic treatment shorten disease in general? How much is it able to shorten a special disease? And, incidentally, can this statistical method assist in solving the problem as to which homœopathic method—for instance, in regard to dosage—promises the best results?*

"The form in which these questions are contained in the rubrics reads as follows:

"1. *How long had the case lasted before treatment in this hospital?*

"2. *What was its duration after treatment began?*

"3. *What was the date of first improvement?*

"4. *What was the duration of the case after improvement first began?*

"It must be evident that if these questions could be answered with a certain degree of accuracy, we should progress very rapidly. Unfortunately, besides scientific ones, there are a great many other obstacles in the way of this progress, not the least of which are found in the labor, time and money required, not only to collate such statistics, but chiefly to elaborate the material after it has been collected and arranged in rubrics as described.

"In order to make these of especial use, it is of prime importance to keep them with greater accuracy than has hitherto been the case. For in glancing over the columns it is to be noticed that important items are often omitted. Thus we find great gaps in the columns concerning length of disease before entering the hospital, length of disease before treatment began, etc.

"It should be added here that even if we can obtain correct

data for future use, these should extend over periods of five or ten years; for we are not working alone for the present, but to leave our statistics in a practical shape for those who come after us. It is certain that there are many questions yet undetermined, and that there are different therapeutic methods struggling for recognition amid considerable partisan strife. During the past century, when there were no homœopathic hospitals, comparisons with other methods were impossible; and hence questions of superiority of practice could not well be determined nor partisan agitation allayed. During the century to come our hospitals of all schools are the sources from which alone true information as to the best methods of practice can be obtained.

“To secure this information we require much more work than we have been able to devote to it. The attending physicians have given all the time and energy they had to spare to the attendance upon patients in the hospital, and to the perfection of their reports as far as they were able, leaving much of the statistical work for the internes to do. These young men and women have done their work faithfully, but their tasks were and are now greater than they are able to accomplish well without overtaxing their strength. For these reasons, additional assistance for the purpose of perfecting our reports from our statistical tables and for their compilation is exceedingly needful. This work our internes are unable wholly to accomplish; and hence it will be necessary that there should be employed by the hospital at least one person as a competent clinical clerk. Such a person could only be selected from among graduates in medicine, or at least from advanced students, whose experience and learning enable them to understand the work done at the hospital. The business of such a clerk should be to keep records as here indicated, and to prepare from them quarterly as well as annual reports, to be revised and corrected by the respective physicians after each one's term of service. It should also be the duty of the clinical clerk to take notes at clinical examinations, surgical operations and autopsies.

“It is furthermore desirable that in future our reports should contain not only a summary of our clinical work, but also detailed descriptions of important or unusual medical and surgical cases, of which a number occur every year.

"Your Medical Board considers this as among the most important work to be done at this or any other hospital; and we are convinced from personal experience that it will fully occupy one person's time, and thus give relief to the medical and surgical internes, and enable them to perform their work with greater exactitude and care.

"Respectfully submitted.

"CONRAD WESSELHOEFT, M.D.,

"HENRY E. SPALDING, M.D.,

"F. B. PERCY, M.D.,

"JANUARY 18, 1898.

"Committee."

It was no easy task, and it still remains a problem for the future how to make the principles here announced operative and of practical value. The changes suggested as to the manner of clinical book-keeping were adopted, as far as possible, at least, by introducing reference-cards containing answers to the main questions propounded in the report; so that if, for want of time and clerical ability, we are unable to render every year a full statistical report, it will at least be possible for any one desiring such statistical evidence to obtain it from the cards and other material so collected.

The main point is this: In order to fully establish the claims of homœopathy as to superiority over any other prevalent therapeutic method, the mere compilation of statistical material from the records of a homœopathic hospital alone would lead to no convincing result. In order to obtain this it will be imperative that other hospitals employing other therapeutic methods should also publish statistical records embracing large numbers of cases; for the superiority of any method is demonstrable only *by means of comparison of different methods*. As long as we had no hospitals, such comparisons were impossible; now that we have them, they should no longer be neglected as the only means to determine the ancient dispute concerning superiority of homœopathy over other methods of practice. It is our duty to make the beginning, because the burden of proof rests upon us; and it admits of no doubt that if we take the initiative, other hospitals will not be slow to follow our example. Although there are signs of an abatement of the ancient feud among "schools," and although we have heard murmurings of the coming together of the "schools," such a consum-

mation is out of the question and actually impossible unless sectional feelings are dropped, and the whole matter is at last handled in a scientific spirit. Such a spirit will become manifest when experimental inductive research takes the place of mere assertion, and when different methods of therapeutic practice are compared in the presence of voluminous facts presented by all parties interested in the solution of this great problem. In endeavoring to find a solution for the same, a new interest will assuredly be created in behalf of pharmacotherapeutics or the treatment of disease by means of medicines. This is evidently sinking into disuse, if not into oblivion, in the "old school" for no other reason than that physicians have never thought it worth while to make proper comparisons of any method of treatment in the sense above indicated. But there is no doubt that those who have made *materia medica* a specialty, as the homœopaths have done, may still predict a great future for the treatment of disease by means of medicine.

HEART REMEDIES.

BY CHARLES MOHR, M.D.,

Professor of *Materia Medica* and Therapeutics, Hahnemann Medical College, Philadelphia.

(Read before the Homœopathic Medical Society of Philadelphia County, September 11, 1902.)

DR. SCHWENINGER, Bismarck's famous physician, has recently said: "Medicine is no longer a science—it's an industry." This remark was occasioned because of the too prevalent use of antipyreticæ, and other coal-tar products, by physicians who pride themselves as practicing "modern methods." His statement might be as pertinently applied to the use of *digitalis*, *strychnia*, and other so-called cardiac tonics and stimulants, if one considers how very frequently these are used in the treatment of acute febrile disorders, in which fear is entertained that the heart will give out.

It is amazing how often heart remedies are brought into requisition when they are not needed, and, worse still, when they are capable of doing positive harm. In my study of the "modern methods" of many young practitioners, I have often

wondered where they received their instruction in medicine; what their training in morbid anatomy and morbid physiology amounted to; how little conception they had of the possible dire effects of well-known drugs in pathological states; and in no field of therapeutics have these questions so forcibly presented themselves as in conditions where a cardiac stimulant or tonic has been deemed essential.

Recently I saw a case of typhoid fever in which such remedies as are usually employed by homœopathic practitioners, viz., bryonia, rhus tox., baptisia and muriatic acid, were prescribed; but lack of faith in their ability to take care of the heart led the physician in charge to prescribe, besides these medicines, *strychnine sulphate*, at intervals of four hours, in doses of $\frac{1}{100}$, $\frac{1}{50}$, $\frac{1}{20}$ and $\frac{1}{10}$ gr. The man died; and, despite the fact that the tetanic effects of strychnine were present for thirty-six hours before death, the very last thing he received was a dose of this poison. Doubtless the physician thought he could do better than those practicing "modern methods," and continued the stimulant in *increased doses after strychnine intoxication appeared*.

Old-school authorities allude to the danger of causing nausea and vomiting, or producing the cumulative effects of digitalis. Others, however, believe this agent has a specific action on the pneumonia coccus, killing the cocci and neutralizing the toxicity of pneumonia toxin. This sounds scientific, and the "modern method" of giving 3 or 4 drachms of *digitalis infusion* finds many followers. Others, again, use 2- or 3-drop doses of the fluid extract to support the heart. The only fatal cases of croupous pneumonia I have seen during the last decade have been adult men and women to whom this agent had been given as a heart tonic, death resulting unexpectedly, and much to the astonishment of the physicians in attendance. One of them said to me, while we were looking at the dead body of a woman who had suddenly died while in the act of getting out of bed to look after the wants of one of her children, "Doctor, I can't understand this; I gave her plenty of digitalis to support the heart, and had it in such good shape that I told the husband this morning his wife would get well."

In the homœopathic school there are not a few practitioners who resort to what they call "physiological prescribing," and

these are the ones most often found using stimulants and *something else*. Among these it is rare to find one who, when he gives strychnine, is not also plying his patient with alcohol; when he gives strychnine, he may be using morphine as well. He often resents the charge that he is not practicing homœopathy, for he says: "I am using the homœopathically-indicated remedy," and mentions several he has employed in conjunction with the agents he has given to induce "physiological" effects. Or, he may say, "I don't believe in homœopathy, or any other kind of a 'pathy;' I'm a *physician*." In passing, it may be remarked of such that he forgets that when a drug produces its specific effects it is not a physiological action, but a pathogenetic one. The effect to be produced is opposite to the conditions present, and hence the selection was not on the homœopathic principle, but on the antipathic principle. Is he a physician if he ignores "pathies?" If so, then, by parity of reasoning, he may ignore "ologies;" then he need think no more of physiology and pathology than he does of homœopathy or antipathy—and perhaps he does not.

There are some who reason well enough, and make what pass for "scientific" prescriptions. Yet even these will forget that an agent selected to stimulate the circulatory apparatus does not stop there. It may, and often will, exert its influence on other physiological systems, and *deranges* what was apparently normal. Thus the symptoms of a drug disease are added to the morbid phenomena of natural disease.

One of the writers of the German school of clinicians, Krönig, has recently called attention to heart failure in pneumonia because of a co-existing dry pleurisy,—a danger often overlooked. Not only is suffering added, but the pain results in a lessening of the depth of respiration, and consequently a diminution of the aspirating action which aids in filling the right auricle. As it is impossible for the ventricles to keep blood circulating unless it receives a free supply from the auricle, the pain should be lessened, thus allowing better aspiration from the great veins, and this can be secured by *morphia*, and much more satisfactorily than powerful heart stimulants; yet *digitalis* is recommended because the ventricle must not be neglected. He points out that in a similar manner pleural exudates, and to a greater extent pericardial effusion, interfere with the filling of the right auricle.

I cite these observations to show how much more secure the homœopathist can feel in his therapeutic application. For just such cases, *bryonia* is the remedy. Read the pathogenesis of this great medicine. Witness its powerful action on the *serous membranes*. There it corresponds to the dry and exudative pleurisy and pericardial inflammation. Observe also that as, of all the serous membranes, the pleuræ are those most readily influenced by *bryonia*, so, of all the viscera, the lungs suffer most from its action. We have short, quick, oppressed breathing; heat and pain in the chest; cough and bloody expectoration, associated with high fever. To these symptoms add the white-coated tongue, the dry mouth, the desire for large drinks of water, the aggravation of pain from motion, etc., and you have a perfect counterpart of the conditions often found in cases of croupous pneumonia; and under its benign effects, when given in small doses, the heart will not fail in such cases as Krönig alludes to, for the curative action begins with the removal of pain, whereby the respirations are deepened sufficiently and the aspirating action is enough increased to insure a good circulation. In *bryonia* cases, neither morphine nor digitalis is needed.

It is not only in acute febrile diseases that the cardiac stimulants and tonics are too frequently and unnecessarily employed. This is notably so of digitalis; but the desire of many practitioners to support the heart and circulation leads them to search for other heart tonics, especially if they distrust digitalis, and *convallaria majalis*, *sparteine*, *strophanthus*, *veratrine*, *sulphate*, etc., are frequently brought into requisition. A practitioner recently asked the writer why it was that so many doctors prescribed digitalis in all manner of diseases and conditions of ill-health whenever the heart showed any signs of weakness. My reply was that they have no confidence in their other therapeutic measures, and if physicians classed as homœopathists do this, they have no confidence in homœopathy. They forget that any medicine or agency, material or immaterial, which tends to improve the general health, or which is lowering temperature in fever, quieting the nervous system, relieving pain and distress, improving the appetite, or in other ways manifesting curative effects, *is having a tonic effect on the heart also*. Therefore, heart tonics, as such, are not needed.

Let me illustrate these points by cases recently seen by me. A woman, aet. 58 years, supposed to be a diabetic, at the same time showing marked symptoms of rheumatic gout, was put upon a strict diabetic diet, and given *sodium salicylate*, and later *antipyrin*, to reduce the large amount of sugar, which was said to have been quite excessive for some months. The sugar was said to have lessened markedly, but the patient was so weak, and exhibited so much feebleness of the action of the heart, which became fluttering and intermittent (probably the result of the *antipyrin*), that she was put upon 2-drop doses of *digitalis fluid extract*; but this had no preceptible effect, and after several weeks of the *digitalis* treatment her regular medical attendant was discharged, and my services were enlisted. On July 17th I secured a specimen of urine, which Dr. Platt examined, finding sugar to the extent of 3.1 per cent. The patient at this time was much emaciated; although hungry at times, could tolerate no food; even the smell of the cooking produced disgust and nausea; suffered much with flatulent distention of the belly, and with intolerable pains in the great toe of the right foot, burning preventing sleep, and touch aggravating the burning. I prescribed *colchicum* 3x. At the present writing the patient is much improved. She sleeps well, has regained much of her strength, eats any food she desires without distress, gained seven pounds within two weeks, and the *heart is acting capitably*. Here, then, the indicated remedy, selected according to the principle of the similars, acted as a heart tonic, because it benefited the patient every way.

A young man, aet. 38, who had been an excessive drinker and smoker, and indulged too frequently in sexual intercourse, while in London in February last had a hæmorrhage, presumably from the lungs. Little attention was paid to this, as the bleeding subsided after some days' rest. On arriving in New York he consulted a physician, who put him on a course of quinine treatment, as he had experienced chills and fever while on shipboard. Business brought him to Philadelphia, where he consulted another physician, who treated him with various tonic medicines, asserting that his troubles were due to over-indulgence in rum, tobacco and venery. During the absence of this practitioner, the patient, who knew something of medicine, prescribed for himself, taking *nux vomica* in tonic doses over

a period of several weeks, but without avail, and on August 14th I was consulted. A glance at the patient was sufficient to convince me he was critically ill; my attention was directed to the lungs, and an examination revealed a large cavity in the left apex, and an area of consolidation in the right apex. Respiration, 36; pulse, 124; temperature, 103.4° F.; heart action very feeble; ankles œdematous. As I suspected tuberculosis, I had a specimen of sputum examined by Dr. Hall, who found large numbers of tubercle bacilli, pus and streptococci. None of his physicians had given the least intimation to him or his family of the state of his lungs; indeed, one had told him his lungs were sound, and that his poor digestion, cough, fever, etc., were due to his excesses. This patient has been under daily observation since August 14th, the course of the disease clearly showing a double infection. If the diagnosis I arrived at had been made by some of our up-to-date doctors he would doubtless have received *heroin* for the cough, *antistreptococcic serum* for the fever, and *strychnine* as a tonic. From me he received neither. I put him to bed; prescribed a liberal proteid diet; interdicted alcohol, and gave him *stannum* 6, every 3 hours. The chief indications for this agent were: Great excitability of the nerves; unbearable restlessness; very easily vexed, becoming angry if his demands were not instantly attended to; lack of strength in hands and feet; weariness and excessive drowsiness after any mental application; profuse sweat after 4 A.M.; cough sometimes dry, but mostly with expectoration of yellow, or greenish-yellow, sweet-tasting mucus; hoarse voice, with sense of great weakness in chest if he indulged in talking. This patient may be considered incurable, and yet he has so greatly improved (at this writing his pulse is 100, respiration, 20; temperature, 100.3° F.) that he is preparing to seek a Western home where the climatic conditions will give him a *chance* to recover. Several days ago he asked me, as it was necessary to prepare a number of legal papers prior to his departure for the West, whether I did not think a dose or two of *strychnine* or a good swig of whiskey would not give him strength to cope with his business difficulties. I replied No, but advised him to take an extra dose of *stannum*, if he felt fatigued. Afterwards he remarked that it seemed strange that the medicine should have had such a "tonic effect."

Several cases of dysmenorrhœa with copious menses have come under my observation where preceding physicians had employed *antikamnia*, and *digitalis* because of very weak heart action, on account of the intensity of the pain and excessive flow. These women would have syncope at the outset of menstruation, with coldness of the hands and feet, sometimes of the whole body, the forehead covered with cold sweat. The abdominal pains would be extremely distressing, accompanied by nausea, vomiting and diarrhœa, with desire for cold water. To these sufferers I gave *veratrum album* 3x. A few weeks since I saw one such case where the radial pulse was intermittent and could scarcely be felt, and the heart was acting very slowly and feebly. Within an hour after two doses of the medicine the pulse had become strong and regular, and at the same time there was a subsidence of the abdominal cramps, nausea and vomiting.

Without multiplying cases, let these I have brought to your attention suffice to emphasize the fact that in the vast majority of cases of curable diseases the remedy or remedies selected according to the principles of homœopathic practice give the heart sufficient support to enable it, in due course, to perform its functions.

I would not be understood to underrate in the slightest degree any of the great advances made in the last few years in the field of scientific medicine. I would, however, enter a plea here for a proper recognition of homœopathy. To my mind the principles taught by Hahnemann and Hering, and in later times by Dunham and Farrington, are as applicable now as they were when first promulgated and practiced. In our studies and investigations into the sciences pertaining to medicine, we must not forget the ART of medicine. The late Dr. Richard Hughes has most truly said: "The great weakness of the general medicine of to-day is that, so far as it is more than blind empiricism, it is an applied science rather than an art. It shifts from heroism to expectancy, and from spoliation to stimulation, with the prevailing conceptions of the day as to life and disease. Maladies are studied with the eye of the naturalist rather than of the artist; and the student is turned out thoroughly equipped for their diagnosis, but helpless in their treatment. Hence the nihilism of so much of our modern teaching. Hence the mis-

erable halfpenny-worth of therapeutic bread to the gallons of scientific sack offered at so many of our society meetings."

Perhaps my audience were preparing to hear something of the use of remedies in heart *diseases*. Much might be said with profit; but I take it for granted that in the case of an acute disease that has been badly managed, or when organic changes have occurred, such as come on insidiously in chronic renal affections, the older members of this society know the value of, and the symptoms and conditions indicating, *actæa racemosa*, *arnica*, *arsenicum*, *cactus grandiflorus*, *kali carbonicum*, *kalmia latifolia*, *lachesis*, *lithium carbonicum*, *lycopodium*, *lycopus*, *naja tripudians*, *phosphorus*, *rhus tox.*, *spigelia*, *spongia*, and *sulphur*.

For the benefit of the younger practitioners of our society who have been prescribing drugs too frequently to induce *physiological* effects in heart diseases,—rarely, perhaps, making a *homœopathic* prescription,—I take the liberty of briefly outlining the prominent conditions indicating the above-mentioned agents.

Actæa Racemosa.—Heart affected by rheumatic poison; recurring attacks of pain resembling angina pectoris; left arm feels as if bound to the side; gloominess.

Arnica.—Cardiac hypertrophy of laborers or athletes; dyspnoea due to fatty heart; great soreness of heart- or chest-walls.

Arsenicum.—Endocarditis and hypertrophy; septic conditions; fatty-granular degeneration; feebleness of heart with constant fainting; angina pectoris; præcordial pain and anxiety; great aggravation from ascending stairs or climbing hills.

Cactus Grandiflorus.—Acute carditis; hypertrophy; valvular disease; aneurysm; spasm of heart, causing it to feel as if compressed with an iron band or clutched by an iron hand; soreness and constrictive sensations.

Kali Carbonicum.—Cardiac asthma; attacks at 2 A.M.; dyspnoea so great must sit up in bed, leaning forward; cardiac cough; exophthalmic goitre.

Kalmia Latifolia.—Cardiac rheumatism; much pain, with slow, weak pulse; valvular insufficiency; pains in rheumatic joints shift suddenly to heart; numbness of left arm; heart intermits every third or fourth beat; shooting pains through the chest to scapula.

Lachesis.—Sympathetic cough of cardiac disease; tremulous irritability of the heart; angina pectoris; conditions worse after any sleep; especially cyanosis, and sense of suffocation.

Lithium Carbonicum.—Heart seriously damaged from acute rheumatism ; renal complications ; throbbing and dull stitches in præcordium ; pressure in region of heart while urinating.

Lycopus Virginicus.—Exophthalmic goitre ; constriction ; tenderness ; irregular action of heart ; cyanosis ; rheumatic pains.

Naja Tripudians.—Chronic nervous palpitation ; in young subjects valvular murmurs after acute rheumatism, or endocardial murmurs following scarlatina ; sympathetic pains arising from other organs, especially ovaries ; constriction and dyspnœa in evening.

Phosphorus.—Fatty degeneration of the heart associated with fatty degeneration of other tissues and organs ; right ventricle most affected ; venous stagnation.

Rhus Toxicodendron.—Hypertrophy from over-exertion ; pulse quick, weak, irregular, intermittent, with numbness of left arm ; trembling and palpitation when sitting still.

Spigelia.—Violent palpitations, with great pressure on the chest ; shooting pains through heart and down left arm, over the chest and down the spine ; rheumatic carditis ; pericarditis ; endocarditis ; darting and lacerating pains during acute exacerbations ; palpitations due to worms ; dyspnœa, compelling patient to sit bolt upright.

Spongia.—Frightful pain, palpitation and dyspnœa, with livid lips and fear of death ; fibrinous deposits upon the valves ; sudden awakening at night with sense of suffocation ; orthopnœa ; cough and concomitants of aneurysm ; exophthalmic goitre.

Sulphur.—Any chronic case where there seems to be a surging of blood to the heart, producing palpitation, gasping for breath, and sensation as if heart were too big for the chest, with other well-known sulphur symptoms.

Before giving either of the remedies here mentioned, there is time to study the pathogeneses, and that one should be administered that has the qualifying subjective symptoms making it the closest similar.

It may be remarked, here, that if a heart be chronically diseased, or where there is hypertrophy, valvular insufficiency or narrowing of the openings, fatty or atheromatous changes, etc.,—if these conditions are unattended with suffering, or if compensation is so complete that all functions of the circulatory system are satisfactorily performed,—better *let the heart alone*.

Give good advice as to diet, exercise, etc., but withhold drugs. If, however, compensation is ruptured, or if distressing pains are experienced, then the safest and most satisfactory treatment is to administer minute doses of whatever medicine is indicated homœopathically.

Little need be said of remedies for functional disturbances of the heart. These are legion. The origin of the disturbance must be traced, and whatever remedy is indicated should be exhibited *secundum artem*. Often these functional heart disturbances are due to emotional, digestive, sexual or other causes, and a due appreciation of the "totality of the symptoms" will suggest the appropriate medicine.

Finally, I may say that we should try to realize whether a *curative* or a *palliative* treatment is indicated. Of the *curative* medicines, I have said all that may be necessary in a paper of this character, and a few remarks on *palliative* treatment may be in order and profitable. We all recognize the fact that we encounter incurable cases; that the best we can do is to relieve distress, and, if possible, prolong life. While my own study, reflection and experience induce me to believe the *similar* remedy is the best *palliative*, all other things being equal, yet I freely admit sometimes, *sometimes*, we must resort to measures non-homœopathic—antipathic, if you will. Yet here we should exercise the greatest care, to be sure that we are not adding to the distress of our patients instead of relieving them. This brings me to say something again of *digitalis*, and other drugs of that class, prescribed to relieve dyspnœa, dropsy and other distressing phenomena, as a result of impaired or faulty circulatory action. Before prescribing such agent, we must appreciate the state of the heart-muscle, of the blood-vessels, of the kidneys, and the digestive organs. On these conditions much more depends than is usually appreciated. This is all-important if we administer doses sufficiently large to induce *drug effects*. Take the universally-used *digitalis*, for instance. If the heart cannot pump blood through the arteries in increased quantity; if the myocardium has undergone such degeneration that it is impossible to improve the nutrition of the heart; if the kidneys are in a condition to exclude elimination of the drug or poisonous materials circulating in the blood-current, then *digitalis* can do more harm than the disease itself.

THE INDICATIONS FOR BRAIN SURGERY—A PAPER FOR GENERAL PRACTITIONERS.

BY WESTON D. BAYLEY, M.D.,

Lecturer on Insanity and Clinical Neurology, Hahnemann Medical College, Philadelphia ;
Junior Neurologist, Hahnemann Hospital.

OCCASION for operation on the brain falls theoretically under two distinct classes, and for each of these an entirely different mental process is requisite in determining the necessity for surgical interference.

First are the cases where, from some obvious injury to the head or palpable disease of the skull, the need for surgery may be distinctly determined by objective conditions which appeal immediately to the sense of sight and touch. This I am going to term "surgical necessity."

Second are the cases which do not appeal directly to the special senses. There is no objective evidence of a lesion; but the history of the case and the general symptoms present, when duly interpreted, suggest the presence of a lesion in such and such a place, and of such and such a character, without there being any possibility of directly observing it. This I am going to term "neurological necessity."

In surgical necessity for brain surgery, then, the indications are direct and obvious; in neurological necessity they are indirect and inferential.

Of surgical necessity this paper will have little to say, as it is a field for the surgeon rather than the neurologist. There is, however, one aspect of it too important to pass unnoticed, and that is in the matter of the common injuries to the head, concerning which some very erroneous opinions have been prevalent. A very considerable experience with head injuries leads me to make, and very earnestly emphasize, the statement that we cannot estimate the amount of damage done to the skull or brain by the local appearance of an injury to the head. The writer has repeatedly seen extensive fractures of the skull without there being even bruising of the scalp, or with a scalp wound distant from the area of fracture. Not once, but many

times, he has seen patients with consciousness preserved, or, perhaps, who had even walked into the hospital themselves, showing slight scalp laceration, but having in reality a crushed skull. Only to-day, as if to emphasize these views, a boy was gathered up from a trolley accident, recovered consciousness in the ambulance, retained consciousness, had no pupillary symptoms, but yet in whom we found a fracture running from the orbit almost to the external occipital protuberance, with a second and divergent line extending downwards from above the ear towards the foramen magnum, and this with a complete shelving of the upper line of fracture over the lower one. Think of it! With a little half-inch scalp wound, not directly over the fracture, and no general symptoms to speak of!

Every case of head injury should be most carefully examined, and the scalp should be freely opened and the skull explored if there is the slightest doubt; indeed, I am almost ready to urge that every case of head injury be adequately explored before it is permitted to pass out of observation. Over the site of fracture there is often an œdematous condition of the scalp or a hæmatoma which serve as important guides in exploration. In the absence of local guides, and there still being reason to believe the skull is fractured, the author has for some years advocated the post-mortem incision as being the most free from anatomical and cosmetic objection, and at the same time most efficient for exploring large areas of skull. Numerous cases could be cited in support of these positions, but I am going to ask you to take them for the present "on faith," while we turn to the consideration of

Neurological Necessity.—Huxley's delightful essay on "The Method of Zadig," from which Conan Doyle must have gotten inspiration for his thrilling "Sherlock Holmes" stories, is a pure illustration of the method of induction as applied to the manner of reaching scientific conclusions in cases where direct observation is impossible. Zadig had not seen the king's horse and the queen's dog, which were lost; yet his knowledge of woodcraft was so complete, and his powers of observation so keen, that his minute description of the animals placed him under suspicion of having stolen them.

Such is the task of the neurologist. He cannot see, hear or feel the lesion; and yet, by a painstaking study of the symp-

toms and a piecing together of the circumstances in a given case, it is frequently possible to exactly locate the position of a morbid condition in the brain, and even to determine beforehand its probable character. This is less certain, and seemingly less brilliant, than the method of surgical necessity, because it is infinitely more complex. Let me cite an illustration :

An elderly man was brought to the Hahnemann Hospital by the patrol, and the officers left without giving any account of the case. There was a contused wound over his left eyebrow; he was unconscious, but could be partially aroused, when his talk was incoherent and could not be understood, and he quickly lapsed into stupor. An empty 3-ounce laudanum-bottle was found in his pocket.

The possible conditions here were, of course, opium stupor, which caused a fall and head injury; uræmic or diabetic coma; post-epileptic coma; fractured skull from a fall or blow; apoplexy from cerebral hæmorrhage; and a few other things. An examination of the limbs showed that he had a hemiplegia—that his left arm and leg and the left side of his face were paralyzed. This was important, as it served to exclude some of the conditions just mentioned. Had he poisoned himself with laudanum? I saw him two hours after he was brought to the hospital, and learned that on his admission the stomach had been emptied and opium antidotes promptly administered, because of the circumstance of the empty bottle; but there was no odor of opium to the breath or stomach contents, and the pupils were only moderately contracted, while yet immovable to light. At any rate, opium does not produce hemiplegia, and, even had we regarded him as being poisoned by the drug, we would have had to look elsewhere for an explanation of this symptom, and that “elsewhere” would have been his injury or some independent lesion affecting his right hemisphere.

That the hemiplegia was not an old one we satisfied ourselves by noting the absence of any rigidity of the affected limbs, and by the fact that the deep reflexes on the affected side were not increased. Uræmia, which *can* cause hemiplegia, with coma, by inducing localized brain œdema, was excluded by the negative results of examination of a catheterized specimen. The real possibilities in this case now seemed narrowed down to three propositions :

1. A fall which fractured the skull and caused a subdural or epidural clot.

2. The *contre coup* of a fall or blow on the head, causing a hæmorrhage in or near the internal capsule, without fracture of the skull.

3. An apoplexy from spontaneous cerebral hæmorrhage, which caused him to fall and, incidentally, cut his head.

Between 2 and 3 it would have been impossible to have differentiated *a priori*, because the lesion would have been identical if either was the case, the difference being entirely etiological.

If the hæmorrhage was cortical from head injury, the lesion must necessarily have been a large one; it must have taken in the entire Rolandic area on the right side, because the hemiplegia was very complete. Such a large lesion should have caused stormy brain symptoms—deeper coma than this man presented. It had to be remembered, too, that convulsive seizures, while they may be present in capsular hæmorrhage, are very much more liable where the hæmorrhage is cortical. This man had several slight general spasms after his admission, and an examination showed that his tongue had been bitten.

I was interested to know more about the laudanum element. Did he take it for headache? And was that headache the result of a vascular disease which is apt to terminate in a cerebral hæmorrhage? At this juncture the wife opportunely arrived, and from her we learned that the man was an opium habitue, that he had finished the last dose from that bottle two days previously, and that the dose was no larger than he customarily took. We also learned from the wife that he had been walking around as usual the day before, but that later he went to bed feeling ill, and that he fell on the floor, cutting his head and becoming unconscious. A piecing together of all of these facts led to the opinion that the case was one of spontaneous hæmorrhage in the capsule; but, in view of the several convulsive seizures, it was decided to give him the benefit of the doubt and make an exploratory trephining over the region we knew must be involved in a surface lesion. Such an operation detracts practically nothing from the chances of recovery in case of finding no lesion; and, on the other hand, should the signs have failed, and there be cortical compression in spite of

our evidence in favor of capsular hæmorrhage, it is the operation which will be the patient's salvation.

Dr. Van Lennep explored the contused brow, finding no evidence of a fracture there. A trephine opening over the mid-Rolandic area showed no abnormality. The patient died early the following morning without regaining consciousness. Post-mortem showed two recent hæmorrhages: one involving the right basal ganglia, destroying the internal capsule on that side; the other was in the cortex of the lower left occipital convolution, near the median line. Had this man recovered he would have had, in addition to a permanent left hemiplegia, a right-sided homonymous hemianopsia.

This case is quoted at length, not so much for its intrinsic interest, but simply to illustrate the method of induction and its difficulties as applied to neurological diagnosis. Indeed, in many of these acute head injuries a diagnosis short of the green-room is impossible.

Concussion of the Brain.—To the neurologist belongs that perplexing problem of "concussion of the brain." This term is regarded with so much horror by some of our present-day surgeons as to be ruled out of court by them in every discussion. The banishment from the books on surgery of those parallel columns of supposed differentials between "compression" and "concussion" of the brain was a distinct step in advance; and the unalterable suspicion with which the surgeon regards cases of so-called concussion is certainly warranted by much of our experience. I am prepared to admit that the complacent use of this expression has resulted, and does still result, in instances of quite avoidable death or secondary brain disease; but, with all this, I still believe there is some truth in the idea of "concussion," and am reminded in the present instance of what Mr. Bryant somewhere said, that "Truth gets well even if she is run over by a locomotive." That we do see cases which, from the clinical standpoint, are not inaptly termed concussion, goes without saying; and that the violent displacement of the cerebro-spinal fluid occasioned by a blow on the head does produce cerebral ruptures, lacerations and bruising, has been amply demonstrated. The real difficulty arises as soon as attempts are made, in a given case, to differentiate the two conditions. A case may be a "concussion" at one hour and a

"compression" in the next, by reason of a slow hæmorrhage from a ruptured vessel with a gradually accumulating clot. Again, between the injury which causes momentary loss of consciousness and that which crushes the brain every intermediate grade of damage is possible; and, from this point of view, if we are going to use the term "concussion" at all, it must be held very lightly as a condition which can never be clearly diagnosed in advance of recovery.

Brain surgery has its indications in certain forms of cerebral hæmorrhage, abscess, tumor, hydrocephalus, epilepsy, congenital skull defects, and in recent and remote traumatisms.

Cerebral Hæmorrhage.—For our present purpose, this will be considered as central and peripheral, recent and remote. Traumatic hæmorrhages are usually (though not always) peripheral. The peripheral hæmorrhages are either epidural or subdural. Epidural bleeding is usually from the middle meningeal artery, and is produced by injuries to the temporal region, and it generally produces hemiplegia, with dilatation of the pupil on the same side as the injury. This is occasioned by the blood leaking downward toward the base and pressing upon the third nerve. Subdural hæmorrhages come from the vascular pia mater, and may involve any portion of the brain cortex. It is not always possible to differentiate between these two varieties, although the condition may be surmised by certain peculiarities of the symptoms; for instance, convulsions are more likely in subdural than in epidural hæmorrhage; the slow development of pressure symptoms is more frequently the case in epidural or meningeal bleeding. A differentiation, however, is not so important, since, if we are satisfied of the presence of a cortical hæmorrhage, an exploration is indicated; and if we do not find the clot under the trephine button, we will find it under the dura by opening it, unless our diagnosis has been bad. Of course, our guides may direct us elsewhere than the motor cortex, as when there is aphasia of some kind, or hemianopsia, which lesions would point to quite different regions for our exploration, and, in the case of hemianopsia, would be surely subdural.

Central hæmorrhages are usually from the lenticulo-striate arteries, and are spontaneous, being due to the ruptures of vascular atheroma. These cases have to be differentiated from

thrombosis and embolism—and that is another story. At any rate, surgical interference in central hæmorrhage, in the present state of our knowledge, is, for obvious reasons, inadvisable.

Remote cortical hæmorrhages may become cystic, with the same operative indications, plus (perhaps) those of other chronic brain diseases. The guides for cysts are the same as for hæmorrhage or tumor.

Cerebral Abscess.—The infections of the brain come from without the cranial cavity, and they may be general or local in character and distribution. Thus there may be a suppurative meningitis or encephalitis of a diffused character, or a localized accumulation of pus without general involvement, or the two conditions may be combined. The principal routes of infection are three in number: (1) cranial traumatisms; (2) suppurative diseases of the middle ear; and (3) purulent disease of the accessory sinuses of the nose, or infections of the orbit. The symptoms will, of course, vary according to the line of infection and the character of the process. They will be general and localizing. The general symptoms of brain infection are pain in the head, mental hebetude or delirium, vomiting, vertigo and convulsions. The pulse is slow, unless meningitis be present, when it is apt to be rapid and irregular. The temperature and vaso-motor symptoms common in suppurative disease are frequently present here. Optic neuritis, while frequently present, is said to be less common than in brain tumor.

The localizing symptoms vary with the seat of abscess, and constitute our guides to operation. An abscess from middle-ear disease tends either to the temporal lobe or the cerebellum. If the process be left-sided we are less apt to be misled in diagnosis, because aphasia or paraphasia is apt to develop if the lesion be temporal on that side. The indications point more to cerebellar abscess when symptoms of bulbar irritation supervene, with pronounced vertigo and the drunken ataxia of vermiform involvement. Clinically, the chances are almost even, with the odds a little in favor of the temporal direction. A case of temporal abscess which ruptured into the lateral ventricle, which was opened, drained, and made a perfect recovery, has been elsewhere reported by Dr. Vischer and myself in a joint paper.

In cerebral suppurations from injuries, operative procedure

will be guided by the locality of the injury, or by neurological guides, if they be present and unequivocal. These latter must always be given the preference in exploration (for instance, if there be a definitely localizing kind of spasm or paralysis). Even though the apparent point of infection be more or less distant, it is safer to follow the neurological indications. This rule is applicable to all kinds of head exploration.

Infection and abscess, as an extension from nasal suppurations, has been discussed in the most interesting manner, with the citation of a number of cases, by Grunwald.* A diagnosis of this class of cases must rest on a knowledge of the source of infection and the general symptoms of brain involvement following in its wake. With this data, a frontal exploration is fully justifiable.

Cerebral Tumor.—Any adventitious development within the skull, whether it be inflammatory or not, is, for all clinical purposes, to be classified as a tumor. These are of relatively greater frequency in childhood. In early life we have the tuberculoma, glioma, and sarcoma—gummata, in middle life, being more frequent than the other forms. Tumors may be single or multiple; they may involve “silent” areas or “localizing” areas of the brain. In any case, their presence is to be determined purely according to the principle of “neurological necessity,” either by general cerebral symptoms or localizing cerebral symptoms, or both. Not many tumors are operable, even when they can be definitely localized, for many appear at the base of the brain, or centrally within its substance, inaccessible to surgical interference, but indicating their locality by definite involvement of cranial nerves and other functioning structures deep within the brain. Starr, in his excellent chapter on “Brain Tumor,” in Dercum’s† book, thus summarizes the present status of the surgery of tumors. He says (referring to the 130 recorded cases of brain tumors operated in the previous six years): “Suffice it to say that 47 per cent. of the cases in which operation has been attempted have proved successful, the tumor having been accurately located and successfully removed, with recovery of the patient. Considering that this operation is a new one,—that it has been attempted rashly

* *Nasal Suppuration.* Dr. L. Grunwald. Published by Wm. Wood & Co.

† *Nervous Diseases, by American Authors.* F. X. Dercum, Editor.

in some cases as a last resort, where there was no probability of success and where failure was inevitable,—it may be expected that the percentage of recoveries will in the future be much higher. It is, of course, a discouraging feature that but 7 per cent. of tumors of the brain are open to operation, and that these statistics would indicate, therefore, that but three brain tumors in a hundred will probably be cured by surgical treatment."

As in abscess, the determining symptoms are general and localizing. The general symptoms, which simply indicate that a tumor is probably present, are headache, optic neuritis and atrophy, mental hebetude, vertigo, vomiting, syncopal or epileptiform attacks.

The localizing symptoms serving as guides to the probable locality are, of course, varying. As if adding to our difficulties, it must be remembered that we know of some tumors of slow growth which have reached inconceivable size, even in active areas, without producing much effect; nay, at times being unsuspected. These are, of course, the exception. If the growth is in the frontal lobe, the symptoms are equivocal and mainly mental, producing objective symptoms only as it encroaches on Broca's region, and results in aphasia. Rolandic tumors are much more fruitful in surgical results; here we have monoplegias, perhaps progressing into hemiplegia as the growth extends. With this, or independently of it, there may be localized convulsive seizures, or Jacksonian epilepsy. If with these symptoms, or a suggestion of them, there be anæsthesia or paræsthesia of the affected limbs, we probably must look a little farther backward in the parietal region for the location of the growth; and if the lesion is left-sided (that is, in right-handed people), there may be alexia, or word-blindness.

Posterior to this we get into the occipital region, where, again, a definite localizing symptom is apt to be met with, and that is a hemianopsia of the homonymous kind. A tumor in the first and second convolutions of the left temporal lobe will produce word-deafness,—a condition in which, while spoken sounds are heard, yet they convey no meaning. In this kind of aphasia the patient cannot recollect spoken names, and, in consequence, he cannot frame speech.

Basilar growths produce, in addition to the general symptoms of tumor, a great variety of localizing symptoms by damaging the various cranial nerves and pressing upon the fibres of the medulla, pons, and crura cerebri. Tumors in this region are, of course, inoperable.

Cerebellar growths depend for diagnosis on our knowledge of the fact that damage to the middle lobe of this organ produces a kind of drunken stagger, the cerebellar ataxia. This symptom soon appears, even if the growth is in one of the hemispheres of the cerebellum, because of the fact that the anatomical situation of this structure allows but very little yielding in case of intra-cerebellar pressure being increased. To determine which side the lesion is on, we cannot depend on the direction of staggering, although the majority of cases do stagger away from the side of the tumor. We must be guided by cranial nerve symptoms, or the occurrence of hemiplegic sensory or motor disturbance, due to transmitted pressure to the base of the cerebrum or the medulla. Any operative procedure on the medulla must be undertaken in a purely exploratory way, since we cannot usually determine the exact position of the growth; and of the three surfaces of the cerebellum but one is accessible through the skull; and, furthermore, the proximity of the medulla precludes much surgical manipulation.

It is no part of the present paper to discuss the diagnostic differences of the several varieties of brain tumor; but it is here desirable to call attention to the frequency of gummatus growths in the brain, presenting all the gravity and apparent severity of the other kinds, and yet being entirely amenable to proper therapeutic management. Gummata are of such frequent occurrence that it is expedient to subject all suspected cases of intracranial growth to the remedial test for syphilis. The writer has seen many such cases, even with very formidable brain symptoms, fully recover under suitable medical treatment.

Hydrocephalus consists in a distention of the lateral and other ventricles of the brain by an excess of fluid, this being accompanied by more or less blighting of the development of that organ. If the development of this condition antedates osseous union of the cranial bones, these will be separated at the

sutures by the increased intracranial tension, and an enlargement of the head results. If the disease is acquired after closure and union of the sutures, no abnormality in the shape of the head will be present. In this latter class, while there may be a variety of symptoms indicative of cerebral damage, a diagnosis is next to impossible.

In cases where the diagnosis is obvious and the prognosis bad, it may be expedient to drain off the hyperaccumulation of fluid by one of the several proposed methods. Most of the operated cases die, but enough benefit has resulted in some instances to justify the operation in this well-nigh incurable affection. The method of puncturing the fourth ventricle through an occipital trephine opening I would hesitate to adopt, because of the proximity of the medulla, although this objection is not based on any personal experience.

Drainage by repeated lumbar puncture has found favor with many surgeons, and some good results have followed. This method does not appear to be at all dangerous.

The third method consists in the drainage of one or both lateral ventricles by puncture through the posterior temporal region. This operation, followed by strapping of the skull with adhesive strips, is the most rational procedure we are at present familiar with; and although its mortality is high, it is the best that can be now offered in an otherwise incurable affection.

Epilepsy.—This is a generic term, and includes many convulsion-producing diseases in addition to the so-called idiopathic variety. For our present purpose, we will define three types:

1. Idiopathic or general epilepsy, in which the symptoms, both objective and subjective, do not point to a gross organic lesion.

2. Focal epilepsy, in which there is a definitely localized beginning to the seizures, with or without the collateral evidences of organic brain disease, and with or without subsequent localizing symptoms,—as, for instance, paralysis or anaesthesia.

3. Jacksonian epilepsy, which is a focal epilepsy, sometimes sharply limited, but without loss of consciousness.

Surgery is not indicated in any case of idiopathic epilepsy.

These have been trephined in times past on general principles, and occasionally with temporary suspension of the seizures; but this was not due to any special virtue of the trephining, since any sort of surgical operation on an epileptic may stop the fits for a time.

The focal and Jacksonian varieties are more apt to be grossly organic; but this is not always the case. When there is considerable lesion, some of the general symptoms of organic brain disease already mentioned are usually present; and, with these, the focal character of the attack will indicate the locality of the lesion, and furnish the guide for surgical procedure. Epilepsies of this character, even without evidences of gross cerebral change, in most instances justify the opening of the dura and the removal of the area of brain concerned in the origin of the fit. Especially are we warranted in this when, by means of the brain electrode, we can, by the current on the exposed cortex, exactly reproduce the convulsion, with its focal peculiarity, at will.

As to the results of the surgical treatment of epileptic conditions, individual cases may be cited to show that they are sometimes brilliant; but there are many disappointments, as might be expected in such a serious ailment, so that a cold estimate would be "generally helpful if properly indicated."

This paper does not pretend to cover the entire field of indications for brain surgery; nor even has any one subject been treated in detail, since to have done so would be to expand an essay into a treatise. This must be remembered in any attempt to apply these generalizations to a particular case. But brief reviews of special subjects do serve to refresh our minds on points and lines of treatment easily forgotten in these days, when there are so many things that the general practitioner must have knowledge of in order to keep pace with the times.

THE HOMŒOPATHY OF HIPPOCRATES.

BY CHARLES S. MACK, M.D., LAPORTE, INDIANA.

(Presented at the Indiana Institute of Homœopathy, May, 1902.)

EVER since the time of Hippocrates there has been record of *similia similibus curantur* as one of the laws of cure. There seems to have been no attempt from his day until Hahnemann's to define the particular cure of which *similia similibus curantur* is the law. Even at the opening of the twentieth century there are very many who do not see the need of such definition. These say that *similia similibus curantur* is one of the laws of cure, but not the only one. True. But to drop the matter there is to leave homœopathy's field or domain, as Hippocrates left it, entirely undefined.

The outcome of treatment under the law of similars may, in a given case, be the same as the outcome of treatment under some other law; but the process of cure cannot be the same under one law as under another. For instance: To one patient with pneumonia you give nothing but (as indication arises) an alcoholic stimulant; to another patient with pneumonia you give nothing but a homœopathic remedy—say antimonium tartaricum. Both of these patients get through, and are well again. Assuming that in each of these cases the treatment saved the patient,—that without it he would have died,—the outcome was in both cases the same, namely, health; but the processes toward health were in one case different from the processes toward health in the other case. The immediate effect of the alcoholic stimulant was entirely different from the immediate effect of the antimonium tartaricum. And now, in speaking of the immediate effect of the homœopathic remedy, we are touching upon the *punctum saliens* of the whole controversy over homœopathy. Oh, if we could but get attention to this one point! The controversy over homœopathy will never cease until the disputants understand that the immediate end in any given practice of homœopathy is entirely different from the immediate end in any practice of rational medicine, or in intelligently-practiced empiricism. Note that the partic-

ular cure of which *similia similibus curantur* is the law is an immediate transformation from abnormal to normal (or approximately normal) in vital processes; when processes have become normal, so will their effects. The word *immediate* in this definition does not, of course, refer to time; it simply means that the medicine has no effect mediate to this transformation. With this definition before us, we see that the particular cure of which *similia similibus curantur* is the law transcends the possibilities of rational medicine or of intelligently-practiced empiricism; for in either of these practices one must have in view an immediate end, in itself knowable, as vital processes and changes in them are not; they are known only in their effects. In my little book "Principles of Medicine"* I have defined, with regard to immediate ends sought, not only homœopathy, but also rational medicine and intelligently-practiced empiricism.

I see not how, without accurate definition of the particular cure of which *similia similibus curantur* is the law, it is possible to give a full and satisfactory answer to the perfectly fair question often asked by our old-school friends: "Why do you identify yourself by name with homœopathy, when your practice shows that you believe in rational medicine and in legitimate empiricism just as much as you do in homœopathy?" With the definition above given it is easy to show that *similia similibus curantur* is the law of a cure which transcends the possibilities of rational medicine, or of intelligently-practiced empiricism; and to show that, because of the transcendency of this cure, one may properly identify himself by name with homœopathy, to make known his attitude on what is far the most important issue in medicine to-day, viz., Is rational practice the *ne plus ultra* in medicine, or is *similia similibus curantur* the law of a cure which transcends the possibilities of rational medicine?

The cure above defined can be effected only under the law of similars, and under that law no other cure can be wrought. When, in a given case, we practice something else than homœopathy, we are seeking some other cure. *Homœopathy's field or domain is that of a particular cure which transcends the possi-*

* Chicago Medical Book Co.

bilities of rational medicine or of intelligently-practiced empiricism. Let us dwell upon this. Let us repeat it upon all proper occasions. Let us harp upon it—impress it. It contains the *punctum saliens* of the whole controversy. Let it never be lost sight of. Keep it ever before our eyes—before the eyes of our fellow-homœopathists—and before the eyes of homœopathy's foes. Above all, let us impress it upon our medical students. Their battles for homœopathy are still ahead of them. Their position will be impregnable, and their freedom absolute, if they can accurately define the particular cure of which *similia similibus curantur* is the law, and can show that that cure transcends the possibilities of rational medicine. Unable to do this, they will often be embarrassed in their efforts to spread an acceptable knowledge of homœopathy.

Fellow-practitioners, isn't it possible to wake folks up to the advantage of accurately defining, as Hippocrates did not, the particular cure of which *similia similibus curantur* is the law?

THE UTILITY OF GASTRIC LAVAGE IN THE TREATMENT OF INFANTILE DISEASES.

BY C. SIGMUND RAUE, M.D., PHILADELPHIA, PA.

Clinical Assistant in Pædiatrics, Hahnemann Medical College; Visiting Physician to the Children's Homœopathic Hospital; Clinical Chief Department for Diseases of Children, Hahnemann Hospital Dispensary.

A PRINCIPLE that should always guide the physician in the care of the sick is to aid nature as much as possible with the simplest therapeutic measures, and only resort to the administration of drugs when positive indications for the same are present. Especially does this apply to children in whom injudicious drugging must prove far more disastrous than in adults.

There is also a greater field for the application of prophylactic and simple hygienic measures in the treatment of sick children, as so large a share of the work falling to the pediatricist is purely the result of errors in feeding or deleterious changes taking place in the food either before or after feeding. Disorders of the stomach and bowels are therefore among the commonest of all infantile disorders.

The subject of which I wish to speak is lavage of the stomach. Stomach washing as an adjuvant in the treatment of gastric disorders is a procedure that has long been practiced, but its introduction into pediatric practice is due to the efforts of Epstein, who, in 1883, published a report of 286 cases in which lavage was used in gastric disorders in infants with great benefit and without a single unfavorable result. Since then it has been extensively employed by pediatricists everywhere. Holt speaks of it as one of the most valuable therapeutic measures we possess, and he states that it has been used thousands of times under his directions without any accident whatever. While I have never seen an evil result that could be traced directly to stomach washing, still I feel that it has its contra-indications as well as advantages, and must always be carried out with care and caution. It is hardly necessary to argue in favor of so practical and simple a procedure, or to plead for the acceptance of a mode of practice whose efforts are self-evident and whose application is based purely on the principles of common sense. We have always recognized that in toxic cases the first rule is to apply the stomach-pump. Since we have learned that most cases of acute indigestion and all cases of cholera infantum are toxic in origin, it becomes our duty to immediately empty the stomach under these conditions unless nature has helped herself and free emesis has set in. The passage of a tube into the infant's stomach is, as a rule, accompanied by no depression and only slight discomfort, which is not to be compared to that resulting from severe nausea or artificially-induced vomiting. By this method we not only empty the stomach, but we are also able to wash it out thoroughly and remove every vestige of harmful matter and abnormal secretions, in consequence of which, recovery from an attack of acute gastritis is more prompt than under ordinary circumstances. Besides, remedies are better able to act when taken into a clean stomach than in one containing decomposing food and mucus.

It is not, however, only in acute conditions in which lavage is of benefit; in subacute and chronic gastritis, fermentative dyspepsia and dilatation of the stomach, it has proven very useful. Daily lavage for the purpose of removing tenacious mucus that interferes with the digestive process, or for drawing off undigested food and gases where they have accumulated, is a

most valuable adjuvant in the treatment of chronic gastritis and dilatation. These conditions are by no means rare, as anyone having extensive practice among children knows.

Lavage is highly recommended to allay gastric irritability and control distressing vomiting associated with obstruction of the bowels. In acute gastritis with uncontrollable vomiting there is no method of treatment so efficacious as lavage.

I wish to refer to another use to which the stomach tube may be put with great advantage, namely, for the purpose of putting food into the stomach. It may seem uncalled for to administer food in this manner, but the clinical experience upon which it is based fully justifies it. The most rebellious stomach retains several ounces of food poured in through a tube when a teaspoonful taken by mouth will be immediately vomited. Kerley has brought this fact out prominently, and he explains it on the grounds that the passage of the tube causes less irritation of the pharynx than the food in being swallowed. Formerly lavage was only used in the rearing of premature infants, as suggested by Tarnier, and in grave acute diseases when the child refused or was unable to take food or drink,—a condition commonly encountered in gastro-intestinal inflammation.

The results of lavage in the conditions above enumerated are positive. For the last few years I have tested it practically both in my hospital work and private practice; and my own experience and that of my associate, Dr. Wm. B. Griggs, who has followed me faithfully in this work, has led me to look upon it as indispensable in the treatment of these maladies. We have seen many cases of gastro-enteric catarrh, and some of gastric dilatation, diagnosed as marasmus (which, by the way, is a symptom, and not a disease), promptly display a tolerance for the proper food and assimilate it after the institution of systematic lavage. That it was a life saver in these cases I am bold to claim.

The apparatus used in stomach washing consists of, first, a No. 11 soft-rubber catheter (Goodrich) for an infant 3 to 9 months old, and for a younger one a No. 10; while for older infants a larger one may be used to better advantage. I am in the habit of enlarging the eye of the catheter, to facilitate the passage of mucus and curds. The catheter is attached to a piece of $\frac{1}{4}$ -inch rubber-tubing, 2 feet long, by means of a short

piece of glass-tubing, and a small glass funnel is attached to the free extremity of the tubing.

The infant, being held upright, seated on the nurse's lap, should be covered with a towel, to prevent soiling the clothing, and the catheter then inserted in the pharynx with the right hand, its tip following the index finger of the left hand, which passes down the base of the tongue. Wetting the catheter with plain water is sufficient, as a rule, on account of the free secretion of mucus in the pharynx, which acts as a lubricant; but if there be abnormal dryness of the mucous membrane, there is no objection to the use of a little diluted glycerine. The child may make efforts at deglutition as soon as the catheter reaches the pharynx, in which case it glides down into the œsophagus easily. More frequently, however, it gags, interfering with the operation. I then wait for a few seconds, until the child draws a long breath, when a gentle push readily forces it into the œsophagus. All that is then required is to move the catheter along with the fingers, which can be done without changing the position of the hand, until it reaches the stomach. This usually takes place when about ten inches have passed; and, if the stomach be full, some of its contents will escape through the apparatus if its end be lowered. In fact, the catheter can be felt to strike the fundus of the stomach, and after a little experience one can readily tell just where the tip of the catheter is located. It is well to first raise the funnel to allow the escape of gas, which is often present. It is then lowered over a basin, and held there until the stomach contents are drained off. Frequently nothing will come from the stomach until water is poured in through the funnel and a siphon established. Again, the gastric contents may be so thick or tenacious as not to flow through the tube until diluted and broken up. With the funnel held a distance of two feet above the level of the epigastrium, two to four ounces of plain boiled water at 100° F. are poured in, and before the last part of the water has flowed in the tube is pinched, in order to maintain a continuous column throughout the tube. The funnel is then lowered into the basin and the stomach siphoned out. This procedure is repeated until the fluid comes out clear.

It is often advantageous to leave a few ounces of water in the stomach; in case of vomiting, pour the feeding in before

removing the tube. In acute gastritis hot water at 110° F. is more advantageous, and when fermentation of food is a prominent symptom a 1 per cent solution of boric acid may be used instead of plain water. I am also in the habit of using bicarbonate of soda when the gastric contains lactic or butyric acids. In carrying out lavage the same steps are taken, with the exception that the child is kept in the prone position throughout. The removal of the tube must be quickly done, at the same time pinching it to prevent the fluid from running into the pharynx and larynx, thus setting up gagging or a coughing paroxysm.

The contra-indications for lavage are pulmonary or cardiac diseases, with cyanosis or embarrassment of respiration, extreme debility, and ulceration of the stomach. Exceptionally, we encounter forms of gastritis in which the passage of the tube causes slight bleeding from the stomach, leading one to suspect ulceration,—post-mortem examinations, however, showing the mucous membrane intact. In such a case it is, of course, imperative to desist. Occasionally, also, we encounter an infant in which attempts at passing the tube cause much distress, embarrassed respiration, and prostration. With great care it is often possible to carry out the introduction of the tube; but it should not be long retained, and if after-effects are to be noted it is not wise to persist. The great majority of cases, however, do not mind the tube in the least, and some hardly seem to realize its presence, giving one ample opportunity to wash the stomach. Caution is, however, always necessary; and the child must be carefully watched while passing the tube, while it is in position, and after the operation.

IS IRIDECTOMY ADVISABLE FOR SIMPLE (CHRONIC) GLAUCOMA?—Yes, on account of the rare occurrence of a definite reduction of vision due entirely to the operation. But on account of the equally rare improvement of vision, and the rare possibility of preserving the vision in *statu quo* by operation, we shall first direct your attention to correcting and controlling our patients' habits, particularly as to the amount and character of food and fluids taken, based on the patient's oxidizing powers. Just as early operation in acute glaucoma is the lesson of experience, so, too, early attention to matters of hygiene, diet and refractive errors is the lesson of experience in the prevention of chronic inflammatory and simple chronic glaucoma.—Dr. T. M. Stewart, *Jour. Ophthalm., Otol. and Laryng.*

THE DUAL CHARACTER OF DRUG-USAGE.

BY E. M. HOWARD, M.D., CAMDEN, NEW JERSEY.

It is natural for the lay mind to look upon all drug-action as alike, and to consider the use of any prescription as simply "taking medicine." Some people speak of the various prepared foods as "medicines," while others mean by the expression "taking medicine" that they are using purgatives. It is evident that there is neither public appreciation of the character of drug-action nor of differences in the purposes for which they are used.

The medical profession itself should discriminate more carefully in these matters; but the fact that it oftentimes fails to recognize the underlying philosophy of drug application, or to consider the possibility of at least *two* distinct ways and purposes of using them, is the excuse for the preparation of this paper.

Many of the misunderstandings between medical men and some of the present differences between the two great schools of medicine hang upon a failure to appreciate this diversity of drug-action. Recently a homœopathic physician was denounced publicly by an old-school brother because he had used *digitalis* as a heart-stimulant in the treatment of a case of diphtheria. It was claimed that by so doing he had forfeited all right to call himself a homœopath, and that he had bodily gone over to the old school, and could no longer honestly claim a distinctive name.

I presume there are homœopathic physicians who would make the same criticism, while there are others who, feeling that it is right to use heart-stimulants in such cases, do not exactly know their ethical position in so doing. A right appreciation of the dual possibilities and facts of drug-usage will end such criticism and remove all doubts.

A clear understanding of the thought under consideration can be had by reference to the manner in which different physicians treat *condylomata*. The surgeon may remove these sycotic excrescences by either one of two mechanical ways: he may

cut them off with his knife, or he may destroy them with some cauterizing drug. Suppose he uses *nitric acid*; this burns them off by chemical action; but the effect is a mechanical one, and is exactly parallel with their destruction by the knife. It is an example of the local use of drug-powers for a distinct mechanical purpose.

The physician will treat these same *condylomata* by giving some drug internally in small doses, which, by the changes it brings about, removes the cause of the condition. *Nitric acid*, as well as some other drugs, are known to bring about such changes.

It is plain, therefore, that there are here *two* distinct ways of using *nitric acid* to relieve a patient of *condylomata*. The first makes use of its local caustic effect for the production of a purely mechanical result. It is comparable to the surgical procedure, and is governed by the physical laws of chemistry and mechanics. The second is a curative action of the drug, produced by changes of the vital processes, in ways at present unknown, but most certainly conformable to some law of nature, and intelligently explainable in accordance with the law of *similars*.

Now, what is true of *nitric acid* is true of many drugs in a similar way; and it is also true of great numbers more in one respect, namely, that their most marked physiological effects are used to bring about well-defined mechanical results. For example, purgatives, because of known effects, are used to obtain the definite mechanical result of emptying the bowels of their accumulations, or of draining waterlogged tissues. Diuretics, because of their known stimulant effect on the kidneys, are used for the definite mechanical purpose of relieving dropsical conditions. Emetics, some of which act mechanically and some physiologically, are used for the avowed purpose of mechanically evacuating the stomach. Mydriatics and myotics, because of their peculiar physiological action on the eye, are used for the definite mechanical object of changing the size of the pupil, of dragging the iris out of danger, or of paralyzing the power of accommodation. Opiates and anæsthetics, because of their physiological benumbing power over the nerves, are used for the distinct mechanical purpose of rendering the patient unconscious to pain. Digitalis and other heart-stimulants

are used for the express purpose of forcing the heart to greater mechanical action.

Many of these drugs are known to be, and all of them may possibly become, curative drugs in other conditions and in ways not explainable on mechanical grounds, and so, like *nitric acid*, illustrate the fact that there is a duality of drug-usage which must be recognized, and which is a matter of practical therapeutics entirely outside of and distinct from the usual study of drug symptomatology.

The following are a few of the many specific illustrations that may be drawn from the pages of any old-school work on *materia medica*:

Podophyllum is a valuable purgative, and is used for this mechanical purpose. It is known to be curative in certain forms of diarrhœa. *Aloes* is used as a purgative, and is also curative in rectal troubles with loose bowels. *Colocynth* is a hydragogue cathartic, and so useful in chronic dropsy mechanically; it is also curative in certain neuralgias. *Cina* and *spigelia* have a mechanical effect in the presence of round-worms, and their curative effect in digestive troubles is well attested. *Ergot* is used to produce contractions of unstriated muscular tissue, but it is curative in gangrenous troubles, and this action cannot be explained on mechanical grounds. *Arsenicum* by its local mechanical action will heal ulcerative skin troubles, and it will also cure chronic skin diseases when taken internally in minute doses. *Tartar emetic* will mechanically empty the stomach, and it is also curative in bronchial catarrhs. *Nitrate of silver* is a caustic and an astringent, and is used for these purposes. It is curative in nervous and other conditions which cannot be explained on a mechanical basis. *Mercury* produces notable mechanical effects, but its curative results in syphilis cannot be explained other than by the law of *similars*. *Strychnine* is a wonderful heart-stimulant, mechanically useful, but its cure of catarrhal dyspepsia and dysenteric troubles is not so easily explained.

But why multiply examples? Reference to any old-school authority will show that while an effort is made to develop drugs in the direction of producing some definite mechanical modification of physiological processes, there still remain large spheres of their influence outside of such action; and many

drugs, also, which cannot be so developed, but which have been empirically discovered to have curative effects, and are even considered as specific in certain conditions, concerning which they do not seem to have any rational connection.

It is most gratifying to our school to know that all such curative effects can be shown to be in strict accordance with the homœopathic law.

In this connection it is interesting to note the status of that class of drugs known as *alternatives*, of which Potter states that "they alter the course of the morbid conditions in some way not yet understood—perhaps by promoting metabolism."

The list given includes the following: Arsenic, antimony, aurum, mezerium, sulphur, ichthyol, mercury, colchicum, guaiacum, sanguinaria, calcium, iodine, the iodides, cod-liver oil and phosphorus.

The empirically-discovered value of these drugs as curative agents is amply corroborated by homœopathic experience, and explained in accordance with the law of similars.

It would appear, therefore, that there are but two therapeutic usages recognizable. Either their results are explainable on purely mechanical grounds, or the improvement is produced by some occult influences upon vital processes in ways not at present accounted for.

It would also appear that mechanically explained drug results are those produced upon the function of organs taken *en masse*, while the curative ones are such as are produced by changes in the individual cells of the organs and tissues, and so are beyond the ken of human observation.

For the purpose of further study we might make three groupings of drugs:

First. Such as are used solely for the production of mechanical results.

Second. Such as are never used for mechanical purposes, but which experience has shown to be beneficial in diseased conditions.

Third. All drugs that offer the two distinct forms of usage we are discussing.

Any attempted grouping of this kind will, however, be tintured by individual theory and practice, so that no two physicians would make exactly the same classification. The

fact is, that here we arrive at the exact parting of the ways of the two great schools of medicine. The old, or rational, school of to-day would seek to explain all curative results physiologically, and it bases all prescriptions upon the desire to bring about definite mechanical results. Such a system presupposes perfect knowledge of pathological changes, and a clear understanding of the steps necessary to restore health. It would plead the limitations of present knowledge as the excuse for our inability to base all therapeutics upon such mechanical grounds.

The homœopathic school of to-day recognizes the usefulness of many, if not the most, of these mechanical measures, but believes that the mysteries of nature will never be fully revealed, so that such means cannot become universally applicable; and that in the law of similars we possess a guide to curative effects which will never fail us in the presence of these deeper and most occult cell-degenerations.

These considerations lead to a view of therapeutic philosophy somewhat different from that usually taken. For instance, the use of digitalis as a heart-stimulant is not an evidence of the existence of any law of cure. It is simply an example of practical mechanics; not enough blood being pumped, put on more force and pump more blood. The fact that, in this instance, certain physiological forces are used which happen to have antipathic relationships would signify nothing. Certain prominent physiological powers of drugs are used to produce definite mechanical effects, and there is no law of cure or rule of practice involved, any more than when a splinter is removed from the flesh. Either measure may relieve a patient of suffering and offer an opportunity for a cure, but neither is a curative measure.

The question as to the advisability of such applied mechanics by means of a physiological drug-power must be studied in the light of the possible drug-effects upon the patient's system in other directions, and its pros and cons must be weighed as we do those before any surgical procedure.

In the homœopathic school it would seem that this question of therapeutics has become confused with and obscured by the study of drug symptomatology. The introduction of the terms *primary* and *secondary*, as applied to drug-effects, has proved

most unfortunate. It is impossible to draw any such dividing-line. Drug-action is one continuous chain, of which each symptom is a link so intimately connected with those preceding and succeeding that it is impossible to separate them. The weak heart developed by the provings of digitalis is simply the last link in the chain which began with stimulation and ends with paralysis.

For the purpose of a homœopathic prescription it is necessary not only that we should know the entire range of the symptoms produced by a drug, but must study their sequence of development. Any group of such symptoms taken from any stage of such sequence may point to the use of that drug in a similar condition, at a similar stage of development. Thus, it might possibly happen that digitalis might be the homœopathic *similimum* in the very case in which it is being used for its mechanical effect, and so exert a curative as well as a mechanical effect at one and the same time. This thought would carry the idea of the duality of drug-usage to its last limit, and is, perhaps, too fanciful for practical consideration.

A CLINICAL STUDY OF ONE HUNDRED CASES OF ACUTE BRONCHITIS.

BY G. MORRIS GOLDEN, M.D.,

Clinical Instructor in Medicine, Hahnemann Medical College; Clinical Assistant in the Department of Medicine, Hahnemann Hospital Dispensary, Philadelphia.

For all practical purposes acute bronchitis may be defined as a catarrhal inflammation involving the mucous membrane of the bronchial tubes. The chief or keynote symptoms are those of cough, expectoration, thoracic pain, difficult breathing or dyspnœa.

The clinical type of the disease will vary according to the location of the inflammatory process, and can be divided into (1) Trachea-bronchitis, or bronchitis of the larger tubes and trachea. (2) Simple or mild acute bronchitis, or bronchitis of the medium-sized tubes. (3) Capillary bronchitis, or bronchitis of the smaller tubes. This latter is considered a part of broncho-pneumonia, and will not be discussed at this time.

Before continuing, allow me to state that the cases examined

were taken from the records of the Medical Department, No. 2, of the Hahnemann Hospital Dispensary. As all cases under 14 years of age are assigned to the Children's Department, this fact will have to be borne in mind in considering certain etiological factors, such as age and occupation, as well as the effect of the disease upon the pulse, temperature and respiration, which, from clinical observation, we have learned is more marked in early life.

As regards the etiological factors, I will not endeavor to point out the more remote and minute causes, but will refer to those which present themselves clinically.

Sex has but little influence upon the disease. Of the 100 cases examined, 56 were males and 44 females.

Those of all ages were subject to the disease, with proneness to certain periods of life. Our text-books teach us that the extremes of life are the most susceptible periods; but from this present study I am inclined to believe that the majority of cases occur in young adult and middle life; but no doubt the greatest mortality of the disease manifests itself at the extremes of life. Before giving any statistics, allow me to recall to your mind the one fact that the ages of the patients range from 14 years upward. Seventeen per cent. of the cases occurred between the ages of 14 and 20 years, 33 per cent. from 20 to 30 years, 22 per cent. from 30 to 40 years, and 20 per cent. from 40 to 50 years of age; the remaining 8 per cent. from 50 years on. Thus, over 50 per cent. of the cases occurred between the ages of 20 and 40 years, this being contrary to the general belief.

As regards occupation, practically all the males were laborers, either leading an out-door life, and thus being exposed to sudden wetting, or else were exposed to inhalation of contaminated air. Of the females, 30 of the 44 were employed in doing housework, or were housewives, which leads to sedentary habits, to exposure to draughts, and running into the open air without the proper amount of clothing and protection. So, considering occupation, with its predisposing tendencies, as a whole, we have it forming one of the largest units of the etiological factors, in that it permits sudden chilling of the surface, which leads to a complementary condition of congestion of the internal parts, and so is the most frequent exciting cause of an attack.

Another etiological factor of importance is shown by the frequent existence of a history of repeated previous attacks, and also by the presence of some chronic condition of the nasal or pharyngeal cavities, and in some instances both. I regret to state that I am unable to produce any figures upon the subject, but from my observations I have come to the conclusion that the percentage is rather large in those cases which have had numerous previous attacks of the disease, or in which a chronic catarrh of the upper respiratory tract exists, and is susceptible to acute exacerbations from the slightest cause, the bronchitis being, in such cases, the result of extension.

The influence of season upon the prevalence of the disease is marked, fully 75 per cent. or more of the cases occurring between the months of November and March. The large majority of the cases presenting themselves during the summer months were found to be an acute exacerbation of a chronic bronchitis, or secondary to some heart, lung or kidney disease; and these patients, as a rule, were past middle life.

As to the question of a microbic origin for bronchitis I am not prepared to speak, for such a discussion would require a voluminous paper of itself. The infection, in all probability, is of the mixed type, but thus far we have no definite knowledge upon the subject. The relation of acute bronchitis to the several acute infections is so familiar to us that we will not consider it at this time. Of the pathological changes, suffice it to state that they are those of a catarrhal inflammation of the mucous membrane lining the bronchial tubes, going through the several stages of congestion, extravasation, œdema, swelling and exudation upon the free surfaces of the membranes, a lengthy consideration of which hardly enters into a clinical study of the disease from a general standpoint.

You have, no doubt, one or many times personally experienced the onset of this disease, which manifests itself by a sense of chilliness, rather than a distinct chill, accompanied by general malaise, aching of the limbs, loss of appetite, coated tongue, sense of oppression of chest, slight fever, and accelerated pulse; and these are followed by the characteristic symptoms of the disease, namely, cough, expectoration, thoracic pain or soreness, and shortness of breath. In certain cases the initial symptoms were those of an ordinary nasal or laryngeal

catarrh, the bronchitis being a secondary condition, as the result of extension.

The most prominent symptom in my cases was cough, which occurred in every one of the patients. Cough is dependent upon two factors, namely: first, the amount of the expectoration, and, second, the seat of the inflammatory process—they being directly proportionate to one another. Thus, if laryngeal involvement be present, cough is more marked on account of the great hypersensitiveness of the larynx in inflamed conditions. It has also been shown by experiment and observation that an inflammatory process involves the bronchial tubes at their bifurcation, that cough is a very marked symptom. But let us not forget the fact that we may have marked inflammation and exudation into the smaller tubes, and even occlusion of some of them, with little or no tendency to cough. In the early stages the cough is hard and dry, with little expectoration, and hard to expel; later, as exudation takes place, cough becomes more frequent, the expectoration is more marked, and the sputum is raised with little difficulty. As resolution establishes itself, cough is prominent only in the morning, being due to the accumulation of the secretion occurring during the night.

The next point, then, to claim our attention is expectoration as it occurred in these patients. It was recorded as being present in 82 per cent. of the cases, but I have no doubt that it is present to some degree in all cases at some stage of the disease. In the early stages it was tenacious, viscid, scanty, and expelled with much effort; later, as the disease progressed, becoming more abundant, whitish or frothy in character; still later yellow or greenish in color, expelled in masses, and with comparative ease. It has been stated that if congestion has been severe, associated with weakened vessels, and the subject past middle life, the expectoration may be blood-tinged; but certainly any hæmoptysis, no matter what the patient's age, should insure a thorough search for some pulmonary lesion and for the tubercle bacillus in the sputum; and allow me to state that more than once I have seen what was regarded as nothing more than a simple bronchitis with bloody sputum reveal, upon careful examination, well-marked evidence of pulmonary tuberculosis, the diagnosis being confirmed by finding the bacillus in the sputum.

We cannot be too skeptical as to other causes for hæmoptysis. In certain of my cases the expectoration was loose and copious from the beginning of the disease; in this class the disease was associated with a previous catarrhal condition of the upper air-passages, the attack of bronchitis being the result of extension, so that the secretions of the two catarrhal processes overshadowed one another, with resulting free expectoration from the inception of the bronchitis.

Pain in the chest is probably the most variable of the symptoms, as it occurred in 65 per cent. of cases, while a sensation of soreness was experienced in 17 per cent. more—hence 18 per cent. were without pain or soreness of the chest-wall.

As regards the location of pain and soreness, which may be considered as one: the most frequent site was sub-sternal, the pain extending to either side, being diffuse and described as a raw, burning, hot sensation, or a sense of weight or oppression, and not a decided pain. Pain proper was referred either to the lateral or scapular regions, and spoken of as sharp stitching in character, felt only on coughing or during a deep inspiration; this was doubtless due to an accompanying myalgic condition of the muscles of the chest-wall, as invariably tenderness to pressure was present. The soreness was referred either to the epigastric region or lower down, across the abdomen—it occurring late in the disease, as a result of the over-use of the abdominal muscles in the effort of coughing.

Lastly, dyspnœa, or shortness of breath, was elicited in 15 of the cases; in 75 per cent. of these the patient was past 35 years of age, while 50 per cent. were past 45 years, so that in all probability it was due to certain degenerative lesions which were not sufficiently developed to be discoverable by routine methods of examination. In the remaining 25 per cent., which were under 35 years of age, the shortness of breath could be attributed to a more extensive lesion, *i.e.*, the involvement of some of the smaller tubes.

The pulse-rate ranged from 68 to 120 per minute, and this increase bore the relative proportion of pulse-rate to respiration in the majority of cases; the younger the patient the higher the pulse-rate, and out of proportion to the temperature.

The temperature of no one case exceeded 102.4° F., and the minimum noted was 97.8° F. In 20 per cent. of cases there

was practically no febrile condition, the rise of temperature being between normal and 99° F. The most frequent rise was that between 99° and 101° F., this class comprising 70 per cent. of the cases, while the other 10 per cent. were above 101° F. The highest temperature, as was noted before, was 102.4° F., and this occurred in a child 10 years of age suffering with a general diffuse bronchitis.

The respirations were quite variable, ranging from 18 to 38 per minute; the rapidity depended to a greater degree upon the extent of the lesion than upon the rise of temperature. To illustrate this, several cases with temperatures ranging from 101 to 101.5° F. had a normal number of respiratory movements per minute.

The physical signs are supposed to be conspicuous by their absence, but by careful observation and systematic examination they will be revealed to us with a fair degree of frequency. Upon inspection, increased frequency of respiratory movements was generally revealed; palpation was *nil* in the early stages; while in later stages, when secretion was abundant, rhonchial fremitus could be elicited, and percussion gave a slightly hyper-resonant note.

The prominent physical signs were, however, elicited by auscultation; they consisted of râles of the dry and moist character, associated with a somewhat prolonged expiratory murmur, not localized but diffuse, especially over the upper portions of the chest. Large, dry, sonorous and sibilant râles were detected in 30 per cent. of the cases, occurring early in the disease, and in some instances they remained so throughout the course; these were cases in which the diseased condition was limited to the trachea and larger tubes. Moist râles, both coarse, fine and subcrepitant, occurred in 60 per cent. of the cases. These were heard during both inspiration and expiration, being greatly modified, and in some instances practically absent, after a few efforts at coughing. General diffuse moist râles, of varying size, were present in but 10 per cent. of the cases; they were heard in various portions of the chest, the subcrepitant in the dependent portions, and were associated with a prolonged expiratory murmur of not markedly heightened pitch.

To go into a detailed account of the treatment of acute bron-

chitis would require too much of your time; and, as abundant literature has been written upon the subject, I refer to other articles, and will discuss only a few of the drug therapeutics clinically observed.

In a dispensary practice we know that certain therapeutic measures cannot be carried out, and we have to content ourselves with a few meagre instructions, and rely mainly upon our indicated remedy, which I am happy to say has given very good results. At the present time I am unable to give you any statistical data regarding the therapeutic effects of the several drugs prescribed, but hope at some future date to enlighten you upon that subject.

Of the several remedies used, bryonia was most frequently indicated, being prescribed in 35 per cent. of cases, upon the following symptoms: Larger tubes involved: short, dry cough; scanty expectoration; stitching pains in chest; tightness across chest.

Phosphorus was indicated in 25 per cent. of cases, being administered upon the following indications: Larynx involved, with hoarseness; sensation of heat under sternum, and sense of heavy pressure or weight across chest, accompanied with paroxysmal cough, followed by prostration. Belladonna was prescribed in 10 per cent. of subjects, upon the short, dry, hard cough, worse at night and upon lying down, and spasmodic in character. Where belladonna did not seem to relieve, hyoscyamus generally cleared up the symptoms.

The remaining 30 per cent. of cases were treated by the following remedies: Kali bichromicum administered in those cases in which the smaller tubes were involved, or the bronchitis was of a diffuse nature, and sputum was characteristic; iodide of arsenic in the later stages of disease, with profuse expectoration easily ejected, especially in patients past middle life, with degenerative changes; and occasionally with causticum, pulsatilla, gelsemium, hepar sulph., ipecac, rumex, nux vomica and rhus tox., all of which gave admirable service. The indications for these remedies I need not repeat.

THE OPPORTUNITY OF HOMŒOPATHY.

BY M. W. VANDENBURG, M.D., MT. VERNON, N. Y.

In a peculiar sense the present age is growing more and more opportune for the propagation of the practice of giving drugs according to similars. Antipathy and allopathy have at last worn themselves out, and are being disowned and discarded in the house of their friends. For more than two thousand years historically known, and probably for thousands of years more among the more advanced nations of the East, the rule of practice has been more or less clearly based, from the philosophical standpoint, on the idea of antipathy. At last science and experience have combined to dethrone this medical idol of the ages.

More and more the value of drugs is being discredited by antipathic physicians, until there is an open onslaught against the use of drugs in any case. This extreme reaction is the farthest swing of the pendulum. It will spread wider and wider until all faith in the antipathic and empirical use of drugs will be uprooted altogether, because science shows the futility of such a course of treatment—science, which is another name for exactness in calculating the effects of drugs upon the sick. The science of healing must have some formula of procedure. It has confessedly had none in antipathic treatment that could be relied upon. It had a fine theory; but, like many other fine theories evolved from the inner consciousness regardless of facts, the theory has been so long and so often disproved that it is in the last stages of dissolution. Our friends are up against a wall, and there seems to them but one way of escape, and that is to deny the beneficial effects of drugs *in toto*. Everyone who has used drugs intelligently, according to similars, has learned experimentally that this late theory of the uselessness of drugs is not according to facts; that drugs *do* work a vast amount of good when rightly used; that no theory of fortuitous coincidence, or of occasional benefits in the midst of many failures, will account for these results.

It is in this faithless age that the opportunity for homœopathy

lies. A consistent, intelligent and wise use of drugs according to similars will in the end win out, because such use is based upon facts too apparent to be theoretically disproved.

This is the logic of the present-day drug therapeutics. No one need lose sleep over the results. It is one of those problems whose solution lies in the eternal fitness of things, as our forbears would say, but we say, in the survival of the fittest. We may do something in our small way either to help or hinder the immediate acceptance of this law of cure, but its ultimate acceptance is as good as the coming of free government, or the triumph of modern industrial civilization, or any other of the great world-changes due to advance in education and civilization. As long as there are sick to be cured, and as long as mechanical, hygienic and preventive means fail to ward off all and every disease, so long will drugs remain among the most potent forces useful in restoring health. And all drug therapeutics will in the end settle down to one of two methods: for their mechanical effects, or for their dynamic effects. In the last, the method of similars is based on the logic of facts.

ATROPHY OF THE OPTIC NERVE OF SATURNINE ORIGIN.—The frequency of lead intoxication in factories for accumulators has been noted by several writers. Guibert reports the following case, in which, in addition to the usual symptoms, there was a superadded bilateral optic nerve atrophy. A 29-year-old male, after working one year in such places, developed lead colic. Treatment relieved him in twelve days' time, and he returned to work, only to have a relapse a few weeks later. Shortly after this, a sudden blindness developed which disappeared in six weeks' time, leaving a diplopia. There was, however, a doubtful history of acquired syphilis some six years previously, without any obtainable hereditary history. The patient was a tall, emaciated and cachectic male, who exhibited some cutaneous hyperesthesias. His reflexes were normal, and there was not any blue line on the gums. There was an alternating external strabismus, the patient claiming to see better to the sides than straight ahead. The iris reaction was normal. Vision with the right eye was reduced to the one-hundred-and-sixteenth of normal, and the left vision to one two-hundredths of normal. The visual fields were concentrically contracted, red and yellow perception alone being conserved and better seen at the field of peripheries. The ophthalmoscope revealed a marked atrophy of the temporal segment of each eye, with an absence of all post-inflammatory signs. Alcohol and tobacco amblyopia could be excluded, as could hysteria and practically syphilis: so that the saturnine origin of the amblyopia seemed the most probable. The author believes that better hygienic conditions should be imposed upon such factories.—*La Clinique Ophthalmol.*

EDITORIAL.

THE HOMŒOPATHIC JOURNAL.

THE old fable of the miller with his son and his donkey, and his ineffectual efforts to please everyone, is of such universal application that the statement that it is in a special sense applicable to the editors of medical journals hardly needs an excuse. The difficulties which beset the poor miller were successive, and capable of being overcome for a time, at least, one after the other; but those that surround the complaisant editor are simultaneous, and cannot by any human skill be met, since they nearly always require different and frequently diametrically opposite lines of conduct. The one subscriber wants this, another that; one praises what another blames; and some never praise except when they have something they wish to find fault with. It would not be profitable, though it might be amusing, to spread out before our readers some illustrations of the various kinds of thorns which line the road of the medical editor; but one rose-thorn which has pricked the heel editorial may well serve as the text for mutually edifying comment, while we proceed to extract it under strictly antiseptic precautions.

HAHEMANNIAN MONTHLY:

Gentlemen: I have had specimens of your Monthly, but am not satisfied that it is what I want. I am looking for a *Homœopathic* journal, and must confess I am disappointed. Should I not find what I want, you will probably get an order from me as coming nearest to what I seek.

Thanking you, I am yours, sincerely,

It will be seen that this is a sturdy little note, and very likely to prick anyone but the most thick-skinned of editors by the implication contained therein that this journal is not homœopathic.

It is evident from the whole tone of the note that, while the object of search is clearly expressed in words, in the mind

of the writer the actual thing wanted is only some sort of vague ideal, as yet "without form, and void."

We are inclined to class this want in the intellectual field with those closely allied symptoms in the physical field, usually concomitants of nervous dyspepsia, expressed in our repertories under the terms "an empty, gone feeling," "an aching void," "wants something, but don't know what."

It cannot, therefore, be regarded as impertinent either to the writer of the note or to our readers if we try to find out what constitutes a homœopathic journal.

Those of us upon whose diplomas the ink has had time to become thoroughly dry can recall what constituted a homœopathic journal twenty-five years ago. Reports of cases, either singly or embodied in the minutes of medical societies, made up the bulk of the reading matter, with an occasional attempt to explain the *rationale* of the action of the homœopathic remedy, or to decry some unfortunate "mongrel" who had uttered the word "pathological," or had confessed to using the lower potencies, or to having alternated two drugs. When you come to examine the records of these cases, the entire absence of any endeavor to diagnose the conditions to be relieved is very striking, while the diagnosis of the remedy is very much in evidence. They are most frequently narrations of the disappearance of symptoms, the relative importance of which is usually not at all indicated by the history of the case, during the administration of one or more remedies, chosen on account of their repertorial ability to cover the greatest number of symptoms. In numbers was strength, and many were the schemes devised and advised for most rapidly and thoroughly finding that remedy which would cover the greatest number of symptoms in a given case, which would thus be determined to be the most like, irrespective of other considerations, and which, therefore, must be the one from which a cure was to be expected. It is little wonder that the literature of our school at that time found few if any readers among the ranks of our opponents, or that it failed to produce a favorable impression upon those into whose hands it did happen to fall. There was such an utter want of any attempt to heal the breach necessarily made by Hahnemann between the new art of therapeutics and the medical science of his day that it could not but be repellant to the awakened medical

conscience in the allopathic school, and finally even within the ranks of our own men. The homœopathic journal of that day represented the homœopathy of that day, and so long as it continued to do that, it proved satisfactory. When, however, the homœopathic physician awakened to the fact that although it still remained his highest duty to heal the sick quickly, safely, and pleasantly, his whole duty was not therewith performed, that homœopathy dare not confine itself solely and simply to boasting of past and present achievements in therapeutics, but that if it wished to continue to exist it must show signs of life by growth and development,—that it must seek to bring itself into connection and harmony with the general advance of kindred branches of medical science,—then the journals of the character just described ceased to represent the new spirit of homœopathy. As a natural consequence, in which we can clearly trace the finger of a merciful Providence, they ceased to exist or changed their character.

But what at the present time constitutes a homœopathic journal? Now, as always, the first requisite is that it should be edited by a homœopathic physician.

Next, it should, as far as possible, represent the *status præsens* of homœopathy in its growth and development, and should be edited with due regard to the wants of homœopathic physicians.

Who or what is a homœopathic physician? Fortunately we are not left in doubt as to the correct answer to this question; we have an authoritative definition, sanctioned by the American Institute of Homœopathy. It is the following: "A homœopathic physician is one who adds to his knowledge of Medicine a special knowledge of Homœopathic Therapeutics, and observes the law of *similia*. All that pertains to the great field of medical learning is his by tradition, by inheritance, by right."

To the wants and tastes of such an one a journal must cater if it would deserve the name of homœopathic. We lay no stress upon the fact that in this definition the possession of knowledge of general medicine is placed first, and that a special knowledge of homœopathic therapeutics and the observing of the law of *similia* are superadded as distinguishing characteristics only, but we simply take these three points as indicating what wants and tastes the journal has to regard. It must have

its pages open to any and all advances made either by homœopaths or their allopathic brethren in the great field of medical learning. Its readers dare not be allowed to remain behind, content with the knowledge of medicine they are supposed to possess already, and wrapping themselves in a cloak of sectarian exclusiveness. They are to be made to feel that even if they are specialists in therapeutics, therapeutics is but one part, even if the most important one, of a much wider field of "medical learning, which is theirs by tradition, by inheritance, by right." It is against this feature of the homœopathic journal that most objection is so wrongly raised. What would be thought of a Republican newspaper which would entirely ignore the doings of the other political parties, or would leave out all financial reports or comments? What scientific journal, even if devoted to a specialty, does not refer to the progress made or attempted to be made in kindred specialties, or in allied branches of science? The homœopathic journal is not supposed to know, nor, if it did know, to govern itself by the knowledge, that most homœopathic physicians have both the means and the will to subscribe to allopathic journals.

Again, the knowledge of homœopathic therapeutics is to be increased and strengthened by the journal, not by presenting vague reports of cases such as satisfied in the past, but by records which shall answer the demands of progressive medicine of the present day, and shall be able to carry conviction to the inquiring mind. In doing this the journal will at the same time confirm the faith of its readers in the law of *similia*, and uphold them in observing it.

We see then that, by a slight paraphrase of the above definition of a homœopathic physician, we may say that a homœopathic journal is one which, under the editorship of a homœopathic physician, in addition to presenting the progress in the whole field of medical learning, devotes itself to the development of homœopathic therapeutics and the illustration of the law of *similia*.

From this point of view, which we cannot but think is the correct one, we do not hesitate to maintain that the HAHNEMANNIAN MONTHLY is in the highest sense of the word a *homœopathic* journal, worthy the confidence of even the elect.

The thorn is extracted, and the wound has healed by first intention, without danger of tetanus.

FOR THE WELFARE OF THE "BUSY (?) DOCTOR."

A FEW days ago a well-appearing man walked into our consulting-room, announcing himself as Mr. —, a well-known druggist, and stated that he had called simply to make himself acquainted with us. After some perfunctory conversation, he finally reached his real business. It seemed that a gentleman had called at his place two days before to purchase a clean six-ounce bottle. The customer was very particular that the bottle should be clean, for he wanted it to convey a specimen of urine to his physician. Our new friend, the druggist, had asked the patient if he did not know that the firm of which our caller was the head "did that kind of work." To this the patient replied that he did not, and was thenceforth silent. We at once took our caller to task for his infraction of the professional code. He did not see it in that way; or, rather, he would not see it that way. He contended that successful physicians were too busy to attend to detail work, and that if we would but investigate the subject, we would find that the large majority of physicians did not have the time for urinary or other clinical laboratory work; that the number of men who owned microscopes, centrifuges, and other necessary apparatus, was infinitesimally small as compared with the total number of physicians; that the chemical and microscopic work for which his firm was bidding was done, not by their regular employees, but by a graduate of — (mentioning the name of a prominent allopathic college). His remarks, if true, indicated that our profession had certainly sunk to a low level. The attempted violation of the ethical code must be so evident to every one that we need make no comment upon it.

The term "busy doctor" is to us objectionable, if it is to be interpreted, as it usually is, to mean "a man who has time for neither study nor proper examination of his cases." Such an individual does not exist, excepting in his own mind. Systematizing of work, the ability to utilize a few minutes or an hour here and there, and a little energy, will show the force of what we mean. A very important method of economizing

time consists of beginning work early in the day, and keeping at it without interruption until that work is finished. Attention to this point alone will soon demonstrate, even to the busiest of the so-called busy, that he has, after all, an immense amount of spare time in the latter part of the day.

We were told by our caller that the "busy man" did not own microscope, centrifuge, and other apparatus. We do not know why this should be the case. If he is busy and business-like, he can certainly afford to have them. But then we are told that he has not time to use them. We do not believe such a statement. The true reason why microscopes are not purchased more freely is an imaginary financial one; for we doubt a true inability to buy one on the part of a physician who is too busy to use it. We do know that the great majority of physicians have laid out considerable money in buying elaborate gynæcological chairs and tables. A first-class microscope can be purchased for \$82, and this includes a $\frac{1}{12}$ -inch oil-immersion objective. The higher class of chairs and tables cost nearly as much as this. For the microscope, there is no known substitute. For the gynæcological chair, almost anything will do. The ordinary pine-wood kitchen-table is better than many of them. We may, we presume, interpret the celerity with which the "busy man" purchases chairs, etc., to the yearning desire to become an operating gynæcologist, etc. Or, it may be that the microscope requires greater skill than the use of the chair.

Another point that we raised related to the employment of a physician for this purpose. We held that the laborer was worthy of his hire; that the man who did the work was entitled to the entire fee; that part of it should not go to the druggist; that a physician who entered into such a compact could not make examinations worthy of confidence; that if physicians wanted their laboratory work done by someone else, they knew where to take it without the intervention of druggists. And again we were met by the same old song about the busy man: he was too busy to know, of his own knowledge, the capabilities of other men for this work.

Unfortunately, all of us must admit that our friend, the druggist, did state some very unpalatable facts. We do hear men say they are too busy to study or do laboratory work. But such

men are growing beautifully less year by year, and the time is not far distant when they will be unknown. We are sacrificing too much in catering to their wants. Our society meetings are ruined by the cry for their needs. Their greatest need is that they disabuse their minds of the false idea that they are as overburdened with work as they are light in cash, for the plethora of work and the dearth of the wherewithal are very apt to go together in such cases. We have never seen a busy man who did not have time to do even more than he was doing. We have always been mindful of the remark made by our old teacher, J. H. McClelland: "If you want anything done, go to a busy man, or it will never be done." If the so-called busy man, for whose instruction the literature-monger and the specialists are constantly preparing "short, practical, pithy articles," and in whose interests the corner druggist persistently labors, does not arouse himself, he will find ere many years have rolled by that he is a thing of the past. The young and rising generation, well versed in the methods of the laboratory and consulting-room, will usurp his business; and these men, let us pray, will never be too busy to do good scientific work.

PROMPTNESS IN ISSUING SOCIETY TRANSACTIONS.

IF there is any one thing necessary to the prosperity of a scientific society, it is the prompt publication of the essays read at its meetings. Delay means that the members lose heart and lack inspiration. The natural result, then, is that they send their best work elsewhere than to the society. The prosperity of homœopathy is dependent upon the American Institute of Homœopathy. Delay in the appearance of the *Transactions* of that organization is a serious menace to our school. It is needless to say that our pleasure was unbounded when we received, on the seventeenth day of September, the bound volume of the session held at Cleveland less than three months before. On the same day we were also favored with the *Transactions* of the Surgical and Gynecological Society of the American Institute of Homœopathy, which also met at Cleveland in June.

Under such efficient management as that possessed by these

two national organizations, it is unnecessary to say that their success is assured.

Quite naturally, those societies whose secretaries persistently and regularly succeed in getting out their *Transactions* any time between one year after adjournment and the millennium may be expected to retrograde, or even become non-existent.

Several months ago we took occasion to speak on this subject, and at that time we gave our estimate of what we thought was very rapid work in pushing a volume through the press. Secretary Gatchell has done far better than our estimate. In fact, had we been told in advance that he would have the *Transactions* printed and bound in Chicago on the 15th of September, we would have doubted the word of the party making the statement. The Institute's by-laws are very generous, and give the Secretary until December 1st to issue his *Transactions*. This means that Dr. Gatchell has brought forth the volume two months and a half ahead of schedule time.

The pace has been set. A new record has been made.

SURGICAL TREATMENT OF EMPYEMA.—(Dowd.)—For the simple cases, excision of about one and a half inches of the seventh or eighth rib in the posterior axillary line; light ether anæsthesia being generally used; the purulent coagula removed; short rubber drainage tubing held in place by safety-pins introduced; abundant gauze dressing applied, and changed when saturated. If the patient's condition contra-indicates general anæsthesia, an incision into the chest wall between the two ribs may be made under cocaine anæsthesia. Aspiration may be resorted to for the relief of those who are greatly distressed by the pressures of the fluid, or temporarily to relieve the second side of a double empyema after the first side has been opened. Irrigation must be used where there is a foul-smelling discharge, due to necrotic lung tissue. The patients are to be allowed out of bed as soon as possible, and the expansion of the diseased portion of the lungs encouraged by forced inspiration. As to secondary operations, they are not to be performed until good opportunity has been given for healing; usually three months should have elapsed without noticeable signs of improvement. In the secondary operation the expansion of the lung should be encouraged by incising and stripping back, and, if necessary, removing the portions of the thickened area. The recovery is, however, usually complete, and with very little deformity resulting.—*Medical News*, September 13, 1902.

GLEANINGS.

THE TREATMENT OF PNEUMONIA WITH CREOSOTE CARBONATE.—Wilcox (New York), in a paper read before the New York State Medical Association, briefly reviews the various methods of treating pneumonia, and states that so late as 1897 Osler believed that we had no reliable measures at our disposal to combat the toxæmia of pneumonia. Within two years, however, Cassoute and Corgier reported that after continuous administration of fairly large doses of creosote carbonate (containing 91 per cent. of creosote, and made from it by the action of nascent carbon dioxide), in most cases a typical fall of temperature occurred during the first twenty-four hours of treatment, and, if the remedy was persisted in for a sufficiently long period of time, the apyrexia became permanent. Relapses and sequelæ, so frequently seen under other methods, were entirely absent. So positive an assertion could not escape attention. Creosote—better beechwood creosote—is not a new remedy, but its caustic action and its irritating effect on the kidneys when given in necessary amounts have prevented its use. So pronounced were these untoward results that the writer had abandoned its use in pulmonary tuberculosis several years earlier. The daily dose of creosote carbonate was from two to four drachms, the dose interval being six hours. So soon as the temperature reaches the normal the amount is reduced to one-half, and this is continued so long as auscultatory signs persist. What are the results? Cassoute and Corgier report favorably upon eighteen cases; Stokes, seven; Bridges, eight; Meitner, thirteen; Eberson, four; Van Zandt, sixteen; Von Ruck, twenty (complicating pulmonary tuberculosis); Weber, nine; and Thomson, eighteen cases. From these observations the statement of Van Zandt is fair—that creosote carbonate cuts short or aborts a large percentage, mitigates almost all the rest, and in a small percentage of pneumonia there is no result. Certainly, if the early appearance of the crisis is any indication of the value of the treatment, this remedy merits a careful trial.

The author's own experience covers thirty-three patients, with no deaths. The disease terminated by lysis in nine; by crisis in twenty-four. Crisis occurred on the sixth day in one, seventh in two, eighth in nine, ninth in six, tenth in three, eleventh in two, and on the twelfth day in one patient. In two patients above the age of seventy, lysis occurred. Of three alcoholic subjects, in two lysis and in one crisis was noted. Two instances of double pneumonia both terminated in lysis: in one the infection of the two lobes was contemporaneous, in the other by sequence. Aside from the remarkable reduction of mortality, the increased percentage of cases in which crisis is noted is suggestive as to the true significance of that phenomenon, and is an argument for the value of the remedy in nullifying the bacterial activity and its results.

Dr. Wilcox concludes as follows :

The present status of the treatment of pneumonia is especially satisfactory when results are considered. To summarize : 1. Continuous, persistent, and generous administration of creosote carbonate. 2. Careful adjustment of mechanical conditions. 3. Thorough evacuation of toxins by all possible ways. 4. Temporary supplemental oxygen by inhalation. 5. Liquid diet until physical signs disappear.

To be avoided, are antipyretics, opiates, ill-advised external applications and slowly-acting heart remedies, as digitalis.—*The American Journal of the Medical Sciences*, September, 1902.

F. Mortimer Lawrence, M.D.

PATHOLOGY OF EMPYEMA.—(Bivaird.)—By the term empyema is understood a purulent pleurisy, an inflammation of the pleura, accompanied by an effusion of serum, fibrin and pus. This affection is in the majority of cases unilateral, but is at times bilateral, and usually affects the pleura covering the lower lobe.

The most frequent character of the effusion is a thick, creamy exudate, which remains plastered to the affected area. It is well said that to draw a line between sero-fibrinous pleurisy and empyema is impossible. Other interesting features of the condition are its frequency in children ; its tendency to form sacculated effusions ; the frequency of pneumonia, especially bronchopneumonia, as a preceding or an accompanying condition ; and the presence of tuberculosis in only 6 per cent. of cases.

As to the *bacteriology* of empyema, the pneumococcus is present in the great majority of cases, in children especially, in the thick, creamy exudates. The strepto- and staphylococci are found in the cases not associated with pneumonia, and characterized by the thin purulent exudate.—*Medical News*, September 13, 1902.

William F. Baker, A.M., M.D.

NON-TUBERCULOUS PNEUMOTHORAX.—(Fussel and Reisman.)—1. A spontaneous non-tubercular pneumothorax occurs in healthy individuals.

2. The pneumothorax is simple, *i.e.*, there is no formation of fluid.

3. There is rarely any febrile reaction, except perhaps in the very beginning.

4. There is probably a moderate amount of emphysema in the lung which is not recognized during life, and incompatible with health.

5. Aspiration is a certain and safe means of relief, and should be resorted to in severe or prolonged attacks.

6. This form of pneumothorax is benign. All but one of the reported cases recovered, and there was only once formation of fluid.—*The American Journal of the Medical Sciences*, August, 1902.

William F. Baker, A.M., M.D.

POST-OPERATIVE NON-SEPTIC LEUCOCYTOSIS.—(King.)—The method of observation to arrive at the conclusions stated below was (1) a complete quantitative examination of the blood 6 to 24 hours prior to operation ; (2) a leucocyte count made 6 hours after operation ; (3) a second quantitative examination made 24 to 30 hours after the second examination ; (4) a leucocyte count made every 24 hours until all danger of sepsis was passed.

Major operative cases were selected, and those without a history of recent

suppuration. Cases that revealed pus at the operation were excluded. Those of the malignant cases operated upon presented no evidence of cachexia.

The conclusions drawn are :

(a) An increase of from 5000 to 10,000 leucocytes per cubic millimeter following operation in from 6 to 36 or even 48 hours is a normal post-operative condition, provided it be not sustained.

(b) Probably the maximum leucocytosis in the majority of cases occurs in the first 12 hours after operation, and is very transient.

(c) The leucocytosis in the normal reparative process bears but slight relation to the pulse and temperature.

(d) A post-operative leucocytosis of 10,000 or more *above the individual normal* sustained for more than a few hours may be looked upon with suspicion.

(e) The apparent increase in the number of erythrocytes following operation is not caused by an actual increase of the red cells in the circulating blood.—*The American Journal of the Medical Sciences*, September, 1902.

W. F. Baker, M.D.

ENTRANCE OF AIR INTO THE VEINS, AND ITS TREATMENT.—(Goodridge.)—As to the symptoms described by various surgeons: A hissing noise accompanies the entrance of air into veins; the blood-pressure immediately falls; the heart—at first tumultuous, with a churning sound heard over the præcordial area, synchronous with the heart action—becomes rapidly weak and irregular; convulsive twitchings of the entire body occur; at this time (and the preceding symptoms have occupied scarcely 30 seconds) the pulse has disappeared, the heart has ceased except for an occasional impulse, the breathing becomes labored and rapid, and after a few violent inspiratory efforts the patient dies.

To sum up, he says, the following facts seem clear:

(1) The entrance of air into the veins, even in small amounts, is to be dreaded, as it may result in death.

(2) That death is due to gaseous distention of the r. heart, or to air emboli in the coronary vessels, and not to primary respiratory paralysis.

(3) That combined treatment by aspiration and infusion we may expect to be attended by good results.

That large quantities of air may be introduced into the veins without unfavorable result he believes to be a pernicious teaching, and not supported by fact.

As to *treatment*, it may be said that preventive measures are first to be recommended. The radical method consists in aspirating the right ventricle. As the symptoms become urgent, a needle should be inserted into the 4th left interspace one inch from the left border of the sternum; it should be directed obliquely upward and backward, and the r. ventricle will be entered. Aspiration should be continued until the blood comes out unmixed with air; then an infusion of normal salt solution equivalent to the amount of blood lost should be given.—*The American Journal of the Medical Sciences*, September, 1902.

W. F. Baker, M.D.

THE ADMINISTRATION OF SALINE INFUSIONS FOR MENINGEAL SYMPTOMS IN AN INFANT.—Alfred Gordon (Philadelphia) reports the following interesting case with meningeal symptoms occurring in an infant arising from

intoxication from the intestinal tract, promptly relieved by hypodermoclysis of normal saline solution.

The child was 5 months old and subject to diarrhœa (intestinal indigestion). During one of these attacks a drug was prescribed that completely checked the stools. Meningeal symptoms promptly appeared, together with prostration and suppression of urine. There was opisthotonos; convergent strabismus; rigidity of the extremities; retraction of the abdomen. The temperature rose to 104° F.

By means of an hypodermic needle attached to a fountain syringe 15 c.c. of normal saline solution were injected into the outer aspect of the left arm. The pulse immediately improved, and kidney function was restored, and after a repetition of the injection the child made a prompt recovery.

Dr. Gordon makes the following comments at the close of his paper:

There is no doubt that the fluid injected washed out and carried off the toxins by the emunctories.

A very small quantity of the saline fluid is sufficient to accomplish the lavage of the blood at times.

The remedy acts as a stimulant to the circulation to the nerve centers, and as a powerful diuretic.

The effect of the effusions is marked soon by an elevation of the temperature and acceleration of the pulse; this is the so-called "period of reaction." In cases of profound intoxications the reaction is very pronounced.

Possibly these facts may serve as a means of prognosis, *i.e.*, when the immediate reaction of the saline infusion is insufficient or absent, repeated infusions are indicated.—*Therapeutic Gazette*, Aug. 15, 1902.

C. Sigmund Raue, M.D.

ORGANACIDIA GASTRICA: A NEW GASTRIC DISEASE.—Knapp, of New York, in an original article, has used this name to designate a disease of the stomach due to organic acids. The lack of previous discovery is attributed to the cumbersome methods involved, requiring expert knowledge of chemistry. The etiological factors involved are some variety of mold and yeast spores, which are developed in the stomach in the presence of acids, producing organic acids, especially succinic, butyric and acetic acids.

The pathological changes are not those of a pathologico-anatomical nature, but a pathologico-chemical change which may lead up to structural changes in the stomach. The disease is divided into: (1) Organacidia gastrica simplex, caused by the ingestion of large amounts of organic acids, as found in fruits and other articles of diet, the symptoms of which are transitory, manifesting itself in violent cramps, vomiting and pylorospasm, passing off after the use of an emetic or suitable cathartic, but sometimes producing high temperature, 104° to 105° F., violent cramps, vomiting and sweating. (2) Gastrosis fungosa. This is of more chronic nature, having as its initial cause the presence of mold in the stomach, which may be either green or red, and developing small or large amounts of succinic acid. This condition can be diagnosed either by physical appearance of the chyme or in combination with the use of the microscope or the latter alone.

The stomach-contents are aspirated after a test-meal, and again after fasting. Large amount of chyme recovered does not indicate atony of the stomach, but rather the organ's effort to free itself of its contents. In working

against the spasmodically contracted pylorus, due to its irritation by the succinic acid produced, the chyme is finely divided, and, when allowed to stand, settles in the vessel as a fine floury mass. After the aspirated chyme is filtered, the fluid is extracted with ether, and a given quantity is floated over a known solution of ferric chloride, giving at the time of contact a dark mahogany ring, giving then the test for succinic acid. This test should be corroborated by the use of the microscope. A drop of clear filtrate is placed on a glass slide and covered with a cover-glass. At the edge of the cover-glass is placed a few drops of a solution of fuchsin. After staining is complete, a few drops of a decinormal solution of caustic soda is added in the same manner, which decolorizes all except mold and yeast. Some of these molds resemble micrococci and diphtheria and tubercle bacilli. Wherever succinic acid is found, mold is also found.

The symptoms of this disease may depend upon either small or large amounts of succinic acid, in some cases small quantities producing marked symptoms, while in others no inconvenience is suffered. Pyrosis and rapid digestion, with ravenous appetite, might suggest hyperchlorhydria. Spasm of the pylorus is often mistaken for gallstone colic; choking sensations resemble globus hystericus, and polyuria may be taken for diabetes. Vomiting in some cases occurs, when the vomited matter may be green or greenish, resembling bile, but which give negative results when Gmelin's and Pettenhofer's tests are applied. Also, the ejected stomach contents may be red in color, simulating hæmorrhage, but which can be discredited by the microscope and proper chemical test, though actual hæmorrhage may be present, due to rupture of some varicose veins, which, in some old cases, are presented as a sequelæ.

The treatment is (1) dietetic, in the exclusion of any food containing mold or such articles of diet containing large amounts of saccharine substance; (2) mechanical, by the use of lavage; and (3) medicinal, not by the use of bicarbonate of soda, which simply neutralizes the acids and does not act upon the fungoid growths, but the exhibition of hydrochloric, sulphuric, phosphoric or nitric acids, which decompose the organic acids. Sequelæ manifest themselves in inflammation of the pyloric region, insufficiencia pylori, varicose veins, with resulting hæmorrhage from straining or otherwise, and may in time involve structures above the stomach as well as those below it. (3) Zymosis gastrica results from the presence in the stomach of yeast-cells. This condition is brought about by the ingestion of large quantities of yeast containing food and drink. The physical appearance of the aspirated chyme resembles that of *gastrosia fungosa*, though at times, when allowed to stand, will separate into three layers, solid at the bottom and fluid between it, and a solid though lighter layer contains air or gas-bubbles at the top. The odor is intense, due to the presence of acetic and butyric acids. The chemical tests are the same as those for *gastrosia fungosa*, except that the dark, mahogany-red ring obtained by contact must be differentiated, which can be done by the addition of 95 per cent. alcohol and the fluids mixed, when, if butyric acid be present, an orange color appears. The microscope will reveal the yeast chains and budding cells. The symptoms are such as are produced by large amounts of CO_2 in the stomach, giving rise to pain about the heart and palpitation, resulting from pressure; pain on deep respiration, and belching when the gas

escapes from the cardiac end of the stomach, and gurgling when passing through the pylorus. The prognosis, if no complications exist, is good. Treatment is essentially that of gastrosia fungosia, namely, dietetic, mechanical and medicinal.—*N. Y. Med. Record*, September 6, 1902.

Paul F. Felsberg, M.D.

UNGUENTUM CREDE IN THE TREATMENT OF SCROFULOUS ABSCESES.—Haass, of Krefeld, says that in several cases of scrofulous abscess of the neck he has observed rapid absorption after innunctions of unguentum crede, the indurated masses of glands in the neck disappearing at the same time. He employed 2 grammes (30 grains) three times a day, administering it exactly as he would grey ointment.—*Wochenschrift für Therapie und Hygiene des Auges*, May 15, 1902.

F. Mortimer Lawrence, M.D.

THE CHANGES IN THE SPINAL CORD AND MEDULLA IN PERNICIOUS ANÆMIA.—Billings (Chicago) selected the above subject for the Shattuck lecture, recently delivered before the Massachusetts Medical Society. He reported in detail the clinical histories and the findings at autopsy in three cases. His conclusions were as follows:

(1) There is a well-established relation of diffuse cord degeneration with pernicious anæmia.

(2) It seems highly probable that the hemolysis and the cord changes are due to the same toxin.

(3) While the source of the toxin is unknown, the fact that gastro-intestinal disturbance is so common in the disease would lead one to suppose that it is of intestinal origin.

(4) The diffuse degenerations of the spinal cord, which occur in conditions without pernicious anæmia, do not appear to differ essentially from those of pernicious anæmia.

(5) It is possible that a common blood circulating poison exists which may expend its force upon the blood in one individual, and coincidentally upon the blood and spinal cord in others.—*Boston Med. and Surg. Journ.*, September 4, 1902.

F. Mortimer Lawrence, M.D.

TREATMENT OF IMMATURE CATARACTS.—The most prolific cause is drinking lime water; the internal remedies of most service are secale, naphthalin, and sepia. He has found in cases where the lens fibres are not sclerosed, but where the lens is hazy, that considerable improvement can be obtained by the use of his apparatus for applying steam to the eyes. Together with this, he uses gentle massage in the ciliary region. While he does not claim a positive cure, the vision in many cases was improved from $\frac{15}{200}$ to $\frac{15}{10}$. The steam spray in inflammation and opacities shortens the inflammatory course, stimulates and aids in the absorption of opacities of cornu as well as lens. He applies the spray three times the first week, twice the second, and once the third. In addition to the local treatment, he considers the general treatment important.—Dr. E. J. Bissell, Rochester, N. Y.—*Jour. Oph., Otol. and Laryng.*

William Spencer, M.D.

THE VALUE OF TRIKRESOL AS AN ANTISEPTIC IN OPHTHALMIC PRACTICE.—The writer considers trikresol solution (1 to 1000) to be more nearly

an ideal basis for collyria and as an antiseptic solution adapted to the eye than any other solution ever tried in ophthalmic practice. This agent was first recommended by E. A. de Schweinitz, of Washington, in 1894. After two years' use, Jackson finds its bacteriological influence to be all that was claimed. Instilled into the conjunctiva, it causes a very slight, momentary sensation of burning. He has used it as a basis for solutions of cocaine, eserine, most of the mydriatics, and even boric acid solution in some cases; but not for solutions of homatropin or atropin, when repeated instillations are required, since even the slight sensation and increased lachrymation are objectionable. He has found that a solution of 1 to 1000 is free from the risk of making the eye worse in any respect: is an antiseptic solution that will at least keep itself clean, and that it has a distinctly germicidal influence when used to wash out the conjunctiva. While the solution of 1 to 1000 has a very noticeable smell of trikresol, this smell does not remain noticeable about the patient on whom it has been used. In all respects, it seems superior to carbolic solutions to lay instruments in, to keep them from contamination after cleaning. It is superior to formaldehyde solutions for this purpose, because there is no need to remove a source of irritation by rinsing the instruments coming from it in something else before using it upon the eye.—Dr. Edward Jackson, Denver, Colo., *The Ophthalmic Review*.

William Spencer, M.D.

TATTOOING A SUBSTITUTE FOR OCULAR PROTHESIS.—De Wecker strongly disfavours promiscuous enucleation, and believes it absolutely indicated only in cases of malignant tumors, and an incipient or developed sympathetic ophthalmitis. To avoid the practical and normal disadvantages accompanying the use of artificial eyes, he has resorted to tattooing of the globe. The operation is more difficult than on the skin of the arms or trunk, on account of the mobility of the conjunctiva and the frequent presence of cicatricial elements. To assist in restoring the size of the globe and of advancing its position, he divides the recti muscles, which retract, and constructs the eyeball. He details three cases in which the results were so good as to lead patients' friends to the belief that the eye had been restored to normal. He believes that the method would be more greatly employed if a better technique were used by its critics.—De Wecker, Paris, *La Clinique Ophthalmologique*.

William Spencer, M.D.

THE LEUCOCYTE COUNT IN THE SUMMER DIARRHŒAS OF CHILDREN.—Typhoid fever is characterized by leucopenia, heminthisis by eosinophilia; and since these two conditions are liable, under some circumstances, to be confused with simple summer diarrhœa, those facts are important. As to the leucocyte count in the simple diarrhœas, Knox and Warfield (*Johns Hopkins Hosp. Bul.*, July, 1902), by counts in 25 cases, are able to confirm the accepted opinion that the blood of normal children under two years shows a relative increase in small mononuclears and a decrease in polynuclears, as compared with the adult. The number of leucocytes varies so widely in cases of summer diarrhœa that a simple count is of no diagnostic value; but differential counting is of more importance, a relative increase in polynuclears indicating an intoxication with decomposition products in the intestine or with the toxins of bacteria. The increase is, as a rule, in proportion to the severity of the infection.

F. Mortimer Lawrence, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY O. S. HAINES, M.D.,

with the collaboration in German literature of C. Sigmund Raue, M.D.

HOMŒOPATHY IN SURGERY.—When Mr. C. KNOX SHAW, M. R. C. S., remarked, during his presidential address at the British Homœopathic Congress in London, that “the Hahnemannian standpoint has changed *pari passu* with the century’s advance,” he may have expressed his own individual opinion, or he may have been indulging in a little innocent persiflage or twaddle. He certainly did not voice the sentiments of the homœopathic profession, either of England or of America. Mr. Shaw partially explains his position when he relates to his audience how, his earliest convictions of the truth of homœopathy having been confirmed by experience, he then drifted away from therapeutics proper into the domain of practical surgery, where he found that the art of prescribing became less and less necessary. He found also that the fascinations of his specialty were so enthralling and absorbing that there was left but little time for the study of homœopathic therapeutics. This may have been natural; but we do not think it is fair to allow “have-been homœopaths,” nor those who have drifted away from homœopathy, to state the case for our science. There was presented at the International Hahnemannian Association meeting, last June, a paper by Dr. C. E. Fisher. It was reprinted in August *Medical Advance*. It is a paper that is worth reading more than twice. The *Century* people evidently thought so, for it also appears in the September number of that excellent journal. The author thinks that all surgery except that of accident is based upon pathology. That all pathology, including that second to accident, is based upon dyscrasiæ. That all dyscrasiæ are based upon pedigree. And in combating pedigree, dyscrasiæ and pathology, only Homœopathy has thus far been proven to be of special value. Every one will agree with Mr. Shaw when he says there are admittedly limitations to the curative effects of drugs. There are many obstacles to cure and there are many mechanical hindrances to cure which surgery alone is capable of removing. The wise homœopath recognizes this and will not “drug” a patient unnecessarily where the mechanical means of surgery are what that patient needs. But homœopathy not only renders surgical interference unnecessary in many instances, but is needed to cure the patient after the surgeon has done his part well. Dr. Fisher makes this very plain. He pleads for the wider use of the constitutional similitum, both prior to operations and afterwards. He thinks that sulphur bears a marked relationship to tuberculous manifestations, and to those of sarcoma and carcinoma. A very large proportion of subjects of surgical pathology are sul-

phur patients. They are scrawny, unhealthy, stooped, dyspeptic, ill-nourished and constipated. A course of sulphur prior to operation will do much towards securing good results for the surgeon. It often secures better reaction from shock, modifies the ill-effects of the anæsthetic, and induces a better wound state. Iodine is a most excellent constitutional in glandular and in bone surgery, especially the joints of children. In operations upon the breasts, thyroids, cervical and inguinal glands: or in empyemas, effusions, tuberculous infiltrations and chronic bone diseases, iodine should never be forgotten. Calcareia is nearly always needed in surgical children, or in the surgery of flabby, light haired people of relaxed tissues. In bow-legs, knock-knee, hip-joint, Pott's disease, caries and necrosis, this remedy is the surgeon's most valuable helper. And so, in turn, Dr. Fisher has taken up thuja, silicea, symphytum, arnica, hypericum and many other remedies. His remarks upon "pain remedies" are valuable, and may enable us to get along without so much morphia. We advise a careful reading of Dr. Fisher's article.

DIETETICS.—R. Milton Richards, M.D., in *Medical Counselor*, did right when he called our attention to the neglect of dietetics in the curriculum of the average medical college. We may also add that the dietetic management of disease does not receive the attention which its importance merits, even in our text-books and in our current literature. It is time the American stomach was receiving more attention from the standpoint of the dietetist. The students of to-day do not know as much about food values, diet in disease, and the proper preparation of food for the sick, as they should know. Their palates are not uninstructed in dietetical elegancies, but they entertain very vague notions of how such things should be prepared. In these days, when our colleges strive to cover the field so completely, the chair of dietetics should have its place in the curriculum, without a doubt.

PERSISTENT ALBUMINURIA.—We think everyone must have observed that occasionally our cases of nephritis improve under the remedies prescribed for them in every particular, save that we cannot seem to influence the albuminuria. There is a constant drain of albumin, even after other symptoms and signs have seemingly disappeared. Dr. Hughes found that in such instances plumbum was curiously effective. We suppose the sixth trituration of the metal or of the carbonate would be suitable for persistent albuminuria after diphtheria or after confinement.

PSORIASIS.—Dr. Hansen, of Copenhagen, reports (*Hom. World*, August) the case of a girl aged 19 years, who had suffered from psoriasis for ten years. She had been treated allopathically, but with no improvement. It had been noticed that when arsenic was prescribed for her the disease became much worse. Dr. Hansen describes the appearance of the eruption as follows: Papulous, red, with much desquamation and but little itching. The parts affected were the extensor sides of the hands and knees, and the hairy scalp. Appetite was not good. The menses, urine and other functions seem to have been normal. Sepia 3x was the first homœopathic prescription. The skin was cleansed daily with tepid water and soft soap, but no external application was allowed. There was some improvement from this remedy; yet, after two months' trial, we found that it became aggravated, and that desquamation increased, and that the itching was now a troublesome symptom. Itching

much aggravated by scratching, especially in the evening. Her physician then prescribed kali arsenicum 3x trit., as much as a pea, three times daily. A gradual improvement followed, and in a year she was cured. There is, in the minds of many of our school, a feeling that psoriasis is an incurable affection. Yet our literature contains much favorable comment upon the action of the similar remedy that should tend to change this view of the prognosis. It is rather striking that the best results have followed arsenic, when that remedy has been given in medium dilutions; notwithstanding which, we have observed that many physicians seem to prefer the 3x, and even lower. A promising remedy, and one that is comparatively new, thyroïdin, has been recommended as very effective by Dr. Halbert of Chicago. This observer administered the 3x and higher, obtaining splendid results. Other writers mention cures with the 2x. Its action in psoriasis is probably homœopathic. Intense desquamation has been noticed after large doses.

AN INTERESTING STATEMENT.—Here is something that should be interesting to every homœopath who has not already read Dr. Hughes' "Practice of Homœopathy." He says there may be diseases which lie beyond the possible range of homœopathy, and, still more likely, there may be diseases which may not yet have come within its practical range. The following eight instances, continues Dr. Hughes, are the only ones that occur to me in which *homœopathic treatment, being applicable in the nature of things*, is at present so excelled as to be displaced by measures of another kind.

1. The use of cold baths in typhoid fever seems to give somewhat better statistics, as regards recoveries, than our treatment can boast.

2. The recurrence in relapsing fever cannot be prevented by homœopathic remedies, but may be by antiseptics, like the hyposulphite of soda.

3. We have nothing to take the place of full doses of iodide of potassium in tertiary syphilis.

4. In peritonitis from perforation we must give full doses of opium, as in ordinary practice, if we are to have a chance of saving our patients.

5. In cardiac dropsy we can rarely get the good effects of digitalis and its cogeners without the induction of their primary physiological effects, so raising the arterial tension.

6. Nitrate of amyl is a better palliative in the paroxysms of angina pectoris than any homœopathically-acting remedy.

7. The use of iodide of potassium in aneurysm seems outside the range of our method, and it is a valuable piece of practice upon which we can hardly improve.

8. In uræmic coma, measures for relieving the brain of the "perilous stuff" which is oppressing it,—if needful, venesection itself,—are of more avail than the best drug treatment.

Dr. Hughes then calls attention to the fact that these exceptions are so few in proportion to the mass of ills, where the balance is just the other way. Thus we are to be encouraged to commit ourselves freely, with such reservations, to the guidance of the homœopathic law. In order that the readers may appreciate the full significance of these statements, he should read the above table of exceptions *thoughtfully*. Numbers 1, 2 and 5 will not be credited by the majority of homœopaths as they stand. In number 4 the author is speaking of the mechanical effect of opium, which splints a damaged intestine

as the proper mechanical device supports and renders immobile a damaged bone or joint. Number 8 contemplates the mechanical removal of an irritant or poison from the body. Number 3 refers to the action of a chemical dissolvent, in all probability. If we had not witnessed several distressing failures of amyl nitrate in angina pectoris, we should have been more impressed with number 6. Is this a good list, after all? Are half of these statements doubtful or actually untrue, and the other half instances in which "homœopathic treatment, in the nature of things," is inapplicable? The homœopathic remedy will neither paralyze an intestine nor dissolve by chemical action a gummatous deposit, nor will it act mechanically to eliminate an irritant poison from the system. If you are obliged to do these things to your patient, by all means adopt the proper means for their accomplishment. In the nature of things, homœopathically-selected remedies are *not* applicable. Let us avoid "insidious" comparisons.

THE BEST METHOD OF STUDYING MATERIA MEDICA.—Of the many methods employed in the study of Materia Medica, the one referred to by Dr. Fahnestock in *Hahnemannian Advocate* strongly appeals to every earnest student of that branch of medicine. We first obtain, as far as possible, the complete symptomatology of the drug. It is generally apparent to the student that the symptoms can be arranged into classes, according to their importance and occurrence. Three classes are apparent: Those that are *general*, those that are *common*, those that are *particular*. These classes, in turn, may be subdivided into first, second and third grades, according to their degree of importance. General symptoms stand first in importance. All symptoms that are predicated on the patient himself are general, while those predicated on any one organ are particular. The common symptoms, on the other hand, are those which one might naturally expect a remedy to produce. Thus, a remedy producing a feverish condition might be expected to produce thirst. This latter would be common. These common symptoms are those that may be found alike in so many different pathogeneses, and they comprise much of the mass of symptoms that our critics claim might as well be gotten rid of. They may not be useful to the prescriber, but they make a pathogenesis complete. He who can recognize them as common, will have no difficulty in giving them their true value in a proving. The particular symptoms are often peculiar; they attract attention at once; they are often characteristics of the remedy. If we diligently study all our remedies in the above manner, we shall obtain very clear pictures of all those that have been well proven. We obtain a mental image of each remedy, which may be recalled in an instant by the phenomena witnessed at the bedside of the sick. Now, we do not know it to be a fact, but Dr. Fahnestock says that very few physicians *study* the Materia Medica; that is, they seldom peruse their books, save when they are looking up some perplexing group of symptoms. Therefore they do not obtain, nor have fixed in their minds, these clear-cut pictures of the different pathogeneses. May be this explains our quick jumps for the bottle of compound tablets, and our frequent inability to "see" any remedy indicated in a certain case. We are rather inclined to think that Dr. Fahnestock is impetuous when he states "that you can go into three-fourths of all the offices of this fair land, and write your name upon the covers of all the materia medicas in sight." Doctors' wives sometimes

read medical journals, and some of them are sensitive on the subject of good housekeeping.

NEURALGIC HEADACHES.—Neuralgias of the trigeminus give us the most trouble of all the nervous headaches. Dr. H. V. Halbert calls attention to two remedies which have been, in his hands, exceedingly useful in the treatment of the supra and infraorbital, or the supra and inframaxillary forms. The first remedy mentioned is atropine. Of this, the third decimal potency is sufficient, if persistently used. The second remedy to which he refers is physostigma. He does not mention the dose he has been in the habit of prescribing. As the oculist employs physostigma for the reduction of iritic adhesions, in order to diminish intraocular tension, so we may regard it as a remedy par excellence in the neurolemma adhesions which are microscopically found in all forms of cranial neuritis. It may be compared from a symptom standpoint to hyoseyamus, in which muscular twitchings abound, although the latter remedy does not cover the neuralgic features so well. Physostigma does not apply, so well, in the neuralgias from remote reflex causes. Thus in a general neurasthenia we should get far better results from the zincs and other indicated remedies.—*The Clinique*, August.

LENIENCY TOWARD THE MICROBE.—In the recent Congress of Tuberculosis, the question of individual predisposition was held to be of greater importance in the causation of tuberculosis than the microbe. This is about the position that homœopaths, as a school, have steadfastly maintained for some time. Hahnemann recognized the germ theory a hundred years ago, and not only that, but he gave it its true value. He did not call them microbes, bacteria or bacilli, but his name of psora was quite as pregnant of meaning. And, by the way, his anti-psorics hold their own, as regards results, with any of the "antis" since discovered. Our remedies reach the soil in which disease takes root, and render it inappropriate for the propagation of its species. So, after all, it would appear that probably the best way is to assist the bacillus in his scavenging process, which, in fact, is assisting Nature, and this can be done in no more easy, quick or pleasant way than by the homœopathic way.—*Medical Century*. (The time is coming when, at our reunion dinners, we shall hear the microbes joining in that pleasant refrain,—“We’re all good fellows, boys.”)

COUGHS AND THEIR VARIED ORIGIN.—This paper, from the pen of G. B. Rice, M. D., suggests the need of careful physical examination of all patients consulting us for persistent cough, before we prescribe drugs, homœopathic or otherwise. It is very interesting to note how varied the origin of this symptom, and the conviction is forced upon one that our duty lies rather in the direction of searching for the cause of a cough, or removing an obstacle that prevents our selected medicine from acting as it should act. The author cites a number of cases which show conclusively that internal medicine is out of place in the treatment of many such conditions. He refers, for instance, to the case of Master A., who had suffered from a persistent cough for upwards of two years. It had followed immediately an attack of influenzal bronchitis. Doubtless this lad had been dosed with various internal remedies. Dr. Rice found, upon examination, an elongated uvula and enlargements of Luschka's tonsil. He amputated the uvula and curetted the naso-pharynx,

and the cough ceased at once and has not recurred. It would be unfortunate if the possession of a more efficient armamentarium of internal remedies should ever lead the homœopathist to neglect such matters as these. He would certainly not be following the precepts of the founder of our school if he were to do so.—*N. E. Med. Gazette.*

FIVE HUNDRED CASES OF SMALL-POX—NO DEATHS.—Under this title Dr. Munger of Hart, Mich., makes several statements that, being the result of bedside observations, are worthy of careful consideration. He says that neither vaccination nor the administration of variolinum prevent the disease. He found also that where the ulceration was deep, that is through the true skin, nothing will prevent pitting. However, many of his cases were mild, and there was no pitting. Isolation or quarantine is the true preventive of widespread infection. He believes actual contact is necessary to communicate the disease; that is, a person must come near enough to the patient to be within the influence of the exhalations given off by the sick. The most contagious period is about the fourth day. Dr. Munger's treatment was simple and effective. He gave belladonna or bryonia in the pre-eruptive stage. Pulsatilla, arsenic, sulphur, rhus tox., or any remedy that was indicated, during the secondary fever. He lost no cases.—*Hahnemannian Advocate.*

GELSEMIUM.—In gonorrhœa, *old cases*, moderate discharge, but constantly present. Very little dysuria. Cases that have been drugged and have had their urethræ burnt out, without relief. In such cases gels. locally and internally restores the parts to their normal condition quickly. So says Dr. J. E. King. He also finds the remedy efficacious in a large proportion of his cases of insomnia from mental overwork. The patient cannot control his nervous feelings. Cannot remain still long enough to quiet down and go to sleep.

ARSENIC.—I wish to refer to one remedy, arsenicum, which is a particular favorite with me. It seems to be well indicated by the characteristic prostration of the disease. I usually give it from first to last, and it has seemed to be of unquestioned value in maintaining the patient's strength and preventing heart failure.—Dr. H. B. Dale in *Medical Magazine*. (Dr. Dale has had a most favorable experience with antitoxin. He says that he has reached that point where he would not like to treat a case of diphtheria without it.)

THE STATUS OF HOMŒOPATHY.—Dr. J. J. Davis believes that Homœopathy will receive its due appreciation when it has been correlated with the general mass of classified knowledge, *i. e.*, with science. We all admit that Hahnemann was fully a century ahead of his time. Physics, chemistry, physiology, pathology and pharmacodynamics must reach the point where they are able to explain his method of treatment. Physical chemistry and physiology are rapidly developing in that direction. Hahnemann's first great discovery, upon which homœopathy is based, was the opposite effects of the large and small dose. This is now being demonstrated in every physiological laboratory. His second great discovery was that of potentization; of the development of power by subdivision. The physical chemists are rediscovering this. They call it surface energy, energy developed by increase of surface. And so it seems that the medical students of the future will learn of these things in their laboratories before they pass under the teaching of medical men. Let us wait in patience. And while we wait, let us hustle with the *materia medica*.—*Medical Magazine.*

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EDITED BY

HERBERT P. LEOPOLD, M.D.

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A Treatise on Diseases of the Anus, Rectum, and Pelvic Colon.—

By James P. Tuttle, A.M., M.D., Professor of Rectal Surgery in the New York Polyclinic Medical School and Hospital, Visiting Surgeon to the Alms-house and Workhouse Hospitals. With eight colored plates and three hundred and thirty-eight illustrations in the text. New York: D. Appleton & Co. 1902.

With the broadening of the field of rectal surgery which has taken place in the past few years, there has arisen a strong professional interest in this branch.

Time was when rectal surgery was almost entirely the province of the quack, and later that of the faddist; but with the establishment of rectal clinics and the appearance of thoroughly trained specialists who have brought to their aid improved instruments, aseptic technique, and a more exact knowledge of pathology, a great change has occurred. In the past it was made a matter of reproach to the trained surgeon that he had permitted the treatment of rectal diseases to remain to a great extent in such unworthy hands, but rarely nowadays is the reproach deserved. The treatment, operative and non-operative, is now taught in all the more advanced medical schools; and the practitioner who did not receive such instruction, as well as the recent graduate who did, will find a wealth of practical detailed information in this work by Tuttle. It represents the outcome of twelve years' conduct of a large rectal clinic, and it has been written quite as much for the general practitioner as for the surgeon. Much space is devoted to examination, diagnosis, and local treatment. Non-operative measures are invariably given first place, and the author earnestly endeavors to indicate the class of cases in which such conservative methods may be expected to succeed. His description of the various operative procedures is detailed and accurate, and the accompanying illustrations are well-chosen. Dietetic suggestions are numerous, and a valuable chapter on rectal feeding is included. All in all, Tuttle's is probably the most important work on diseases of the rectum that has appeared in the last decade, and as such must attract the attention of almost every member of the medical profession.

The Principles and Practice of Gynecology. For students and practitioners. By E. C. Dudley, A.M., M.D., Professor of Gynecology, Northwestern University Medical School; Gynecologist to St. Luke's and Wesleyan Hospitals, Chicago, etc. *Third Edition*, revised and enlarged. With 474 illustrations, of which 60 are in colors and 22 full-page plates in colors and monochrome. Lea Brothers & Co., Philadelphia and New York. 1902.

The author's aim, as stated by himself, has been to write a practical treatise on gynecology, and in doing so to preserve, so far as possible, the unity of each pathological process as it may affect consecutively the different pelvic organs. In order to do this he has divided his subjects, especially the inflammations, not into chapters, each describing the diverse diseases of a special organ, but instead, and we think wisely, from the standpoint of etiological and pathological sequence. Certainly the student will gain a more rational comprehension of metritis when he understands its close association with vulvovaginitis, salpingitis, ovaritis, and peritonitis. Under this plan the student cannot but realize the functional unity of all the reproductive organs, and will study the various pelvic disorders in the combined forms which they generally assume. That this is essential to a proper understanding of pathological processes, whatever their nature, none will dispute; and the author is to be congratulated upon the success which has attended his effort.

In this, the third edition of his work, thorough revision is apparent. In order to include the recent advances in gynecology, chapter after chapter has been rearranged and condensed, and in this way the equivalent of nearly a hundred pages of new matter has been introduced without enlarging the book to an inconvenient size. It is a handsome book. It is not only profusely illustrated, but the drawings are calculated to show, step by step, the procedures of all the major and many of the minor operations. For example, the consecutive steps in hysteromyomectomy are shown in twelve drawings; salpingectomy in five drawings; vaginal hysterectomy in fifteen drawings; ovariectomy in eight drawings; and so on throughout the list. Such illustrations as these are not merely "pretty;" they really aid the operator in his work and the

student in following him. This alone, irrespective of other merits, will assure continued popularity for the work.

Diseases of Infancy and Childhood. By Henry Koplik, M.D., Attending Physician to the Mount Sinai Hospital; ex-President of the American Pediatric Society. Lea Brothers & Co., New York and Philadelphia. August, 1902.

The association of the name Koplik with a work on diseases in children is in itself sufficient guarantee of its excellence. The book is not an exhaustive treatise on pediatrics, but the subject-matter is so methodically arranged, and the text so terse and thoroughly digested, that in the compass of about 675 pages Dr. Koplik has pretty well covered the entire field.

One of the especial features of the book is the unusually fine illustrations.

It is interesting to know Dr. Koplik's views on some of the newer diseases. For instance, lymphatism he describes as a condition in which enlarged lymph-nodes are found at the angle of the jaw, in the axilla, and in the groin, together with hypertrophy of the tonsils and adenoids. It is found chiefly in rachitic, anæmic children. Laryngismus stridulus is another important symptom. It is to be differentiated from scrofulosis—a clinical entity still recognized by Dr. Koplik. This refinement, however,—the differentiation of adenitis, associated with rickets, from that of scrofula and lymphatism, likewise laryngismus stridulus of rickets from that of lymphatism, and the ordinary form of adenoid vegetations from that found in a special form of constitution—seems like splitting hairs.

The sections on nursing and feeding are excellent, and a practical exposition of the methods of examination precedes the discussion of the diseases of the special organs. Altogether it is, without doubt, one of the very best books on diseases in children.

The Treatment of Fractures. By Charles L. Seudder, M.D., Assistant in Clinical and Operative Surgery, Harvard Medical School. Third Edition, revised and enlarged. Octavo, 480 pages, with 645 original illustrations. Philadelphia and London: W. B. Saunders & Co. 1902. Polished buckram, \$4.50 net; half morocco, \$5.50 net.

Seudder's work on fractures has attained wide popularity because of its extremely practical character. The various methods of treatment are described with minute detail, and the practitioner is not only told, but actually shown by an elaborate series of illustrations, how to apply apparatus. These illustrations, 645 in number, are the most distinctive feature of the book.

In this edition several new fractures have been described, and an excellent chapter on Gunshot Fractures of the long bones has been added. The reports of surgeons in the field during the recent wars have been carefully digested, and the important facts regarding fractures produced by the small caliber bullet have been concisely presented. In many instances photographs have been substituted for drawings, and the use of plaster-of-Paris as a splint material have been more fully illustrated. The work fully maintains its deserved reputation.

Atlas and Epitome of Traumatic Fractures and Dislocations. By Professor Dr. H. Helferich, Professor of Surgery at the Royal University, Greifswald, Prussia. Edited, with additions, by Joseph C. Bloodgood, M.D., Associate in Surgery, Johns Hopkins University, Baltimore. From the fifth revised and enlarged German edition. With 216 colored illustrations on 64 lithographic plates, 190 text-cuts, and 353 pages of text. Philadelphia and London: W. B. Saunders & Co. 1902. Cloth, \$3.00 net.

This recent addition to Saunders' Series of Hand-Atlases is a collection of illustrations which portray with great accuracy the external deformities, the X-

ray shadows, and the anatomic preparations by which fractures may be distinguished. In addition there are many pages of text, in which not only diagnosis but treatment receives due consideration. The illustrations showing methods of dressing are particularly valuable. The work will greatly aid the student in understanding the various fractures and dislocations, and will prove scarcely less valuable to the practitioner in search of a ready-reference volume.

The Diseases of the Nose, Throat and Ear. By Charles Prevost Grayson, A.M., M.D., Lecturer on Laryngology and Rhinology in the Medical Department of the University of Pennsylvania; Physician-in-charge of the Department for Diseases of the Nose and Throat in the Hospital of the University of Pennsylvania; Laryngologist and Otologist to the Philadelphia Hospital. Octavo, pp. 598. Illustrated with 129 engravings and 8 plates in colors and monochrome. Philadelphia and New York. Lea Brothers & Co. 1902. Price, \$3.50 net.

Within the past two years a number of admirable books upon diseases of the nose and throat have been issued, and the reviewer's first question upon catching sight of a new work on laryngology is as to whether it has any possible reason for existence. That this thought is not unexpected by the author of the volume before us is evident in the opening sentence of his preface, in which he expresses a hope that its *raison d'être* may be found in the sections on treatment and in the constant thought he has given to those who wish to know not only *what* to do, but *how* to do it.

The work is evidently that of an experienced teacher. From his first chapter, dealing in a simple and practical manner with the selection and care of instruments, to his last, the customary one on formulæ, the hand of the clinician is apparent. He errs, if at all, on the side of simplicity. He devotes little space to pathology, but gives detailed attention to methods of examination and diagnosis. He recommends comparatively few instruments, but gives clear instructions as to how they should be used. As a rule he advises but a single method of treatment, that which he personally has found most effectual; and this is precisely the sort of information that the practitioner desires. This clear style renders his therapeutic directions easy to understand and apply. These are features which, while they may lead the advanced laryngologist to prefer larger and more comprehensive works, will in all probability insure for the present volume a kindly reception and genuine appreciation from beginners generally, and especially from that large class of physicians by whom diseases of the nose and throat are regarded as constituting a department of general practice.

A Text-Book of the Surgical Principles and Surgical Diseases of the Face, Mouth and Jaws. For Dental Students. By H. Horace Grant, A.M., M.D., Professor of Surgery and of Clinical Surgery, Hospital College of Medicine; Professor of Oral Surgery, Louisville College of Dentistry, Louisville. Octavo volume of 231 pages, with 68 illustrations. Philadelphia and London: W. B. Saunders & Co. 1902. Cloth, \$2.50 net.

This work, as befits a text-book designed for the dental student, lays special stress upon surgical principles as applied to the oral cavity, and, in addition, discusses in detail such lesions as are apt to visit the dentist for diagnosis and treatment. It evidently follows closely the course of instruction followed in our modern dental schools, and includes, moreover, a variety of emergency procedures such as dentists and physicians alike are liable to encounter. It is clearly and tersely written, and will unquestionably find many readers among medical as well as dental students.

A Text-Book of Materia Medica, Therapeutics, and Pharmacology.—By George F. Butler, Ph.G., M.D., Professor of Materia Medica and Therapeutics in the College of Physicians and Surgeons, Chicago, Medical Department of the University of Illinois, etc. Fourth edition, thoroughly revised. Handsome octavo volume of 896 pages, illustrated. Philadelphia and London: W. B. Saunders & Co. 1902. Cloth, \$4.00 net; sheep or half morocco, \$5.00 net.

The new edition of this commendable work is offered to the profession after a careful and complete revision. The pharmacology and therapeutics of each drug have been thoroughly revised, incorporating all the recent advances made in pharmacodynamics.

The following important alterations and additions have been made in this edition, namely: A thorough remodeling of the opening chapters to bring them into accord with recently discovered biological phenomena and natural interpretation of the disease process as reactive and self-preservative. Numerous changes have been made in the expressions of opinion regarding the utility of certain drugs, notably the newer synthetics, which larger experience has modified, resulting in more definite conclusions. Many of them have been introduced, their actions discussed, and their therapeutic uses fully expounded, while considerable attention has been paid to their incompatibles.

But perhaps the most important addition is the chapter on the newer theories of electrolytic dissociation and its relation to the topic of pharmacotherapy, and the relevant discussion added of the simpler relations of chemical structure to drug-action. The profession will undoubtedly greet most cordially this new fourth edition of a work supplying the student of medicine with a clear, concise and practical text-book, adapted for permanent reference no less than for the requirements of the class-room.

The International Text-Book of Surgery.—In two volumes. By American and British Authors. Edited by J. Collins Warren, M.D., LL.D., F. R. C. S. (Hon.), Professor of Surgery, Harvard Medical School; and A. Pearce Gould, M.S., F. R. C. S., of London, England. Second edition, thoroughly revised and enlarged. Vol. I. General and Operative Surgery. Royal octavo of 965 pages, with 461 illustrations and 9 full-paged colored lithographic plates. Vol. II. Special or Regional Surgery. Royal octavo of 1122 pages, with 499 illustrations and 8 full-paged colored lithographic plates. Philadelphia and London: W. B. Saunders & Co. 1902. Cloth, \$5.00 net; sheep or half morocco, \$6.00 net.

In planning this work the editors and co-workers have kept constantly in mind the needs of both student and practitioner. The result—a masterly exposition of the art and science of surgery, untrameled by antiquated traditions. In its realization they have given to medical literature an invaluable text-book, embodying a clear but succinct statement of our present knowledge of surgical pathology, symptomatology and diagnosis, and such a detailed account of treatment as to form a reliable guide to modern practice. In this new edition the entire book has been carefully revised, and special effort has been made to bring the work down to the present day. The chapters on Military and Naval Surgery have been very scrupulously revised and extensively re-written in the light of the knowledge gained during the recent wars. The articles on the effect upon the human body of the various kinds of bullets and the results of surgery in the field are based on the latest reports of the surgeons in the field.

The chapter on Diseases of the Lymphatic System has been completely re-written and brought up to date; and of special interest is the chapter on the Spleen.

The already numerous and beautiful illustrations have been greatly increased, constituting a valuable feature—especially so the seventeen colored lithographic plates. The work is excellent; we know of none to surpass it. It is clear, concise, and up to date.

Saunders' Question Compends—Essentials of Diseases of the Ear.—By E. B. Gleason, S.B., M.D., Clinical Professor of Otology, Medico-Chirurgical College, Philadelphia; Surgeon in Charge of the Nose, Throat and Ear Department of the Northern Dispensary, Philadelphia, etc. Third edition, thoroughly revised. 16 mo. volume of 214 pages, with 114 illustrations. Philadelphia and London; W. B. Saunders & Co. 1902. Cloth, \$1.00 net.

This valuable little help, one of Saunders' Question-Compend Series, has reached its third edition. The book will be found of service, not alone as an aid to the student, but also to the physician who wishes to take a post-graduate course in Otology, enabling him, as it does, to acquire the rudimentary facts of the science with as little preliminary reading as possible.

The essentials of Otology have been stated concisely, without sacrificing accuracy to brevity. The diagnosis and treatment of diseases of the ear have been brought absolutely down to date by a thoroughly scrupulous revision; only such methods of treatment being included, however, that have personally proved efficacious in the majority of cases. Besides carefully revising the old text, many interpolations of new matter have been made, thus somewhat increasing the number of pages in the present edition.

The illustrations—many from original drawings—have been selected with the aims of the book constantly in view; and they form a very commendable feature of the work. Indeed, the little volume before us will unquestionably continue to be one of the most popular of Saunders' unequalled Question-Compend Series.

Saunders' Question Compends—Essentials of Histology.—By Louis Leroy, B.S., M.D., Professor of Histology and Pathology, Vanderbilt University, Medical and Dental Departments; Pathologist to the Nashville City Hospital, etc. Second edition, thoroughly revised and enlarged. 16 mo. volume of 263 pages, with 92 beautiful illustrations. Philadelphia and London: W. B. Saunders & Co. 1902. Cloth, \$1.00 net.

This valuable work has been designed not only as an aid to the beginner, but also to help the practitioner who, having graduated at a time when histology was not taught in all the colleges, desires to gain sufficient knowledge of the subject to facilitate his better understanding of pathology. Both these aims it admirably fulfills, as is evidenced by the demand for a second edition in so short a time.

In this edition a number of new original illustrations, mostly photomicrographs, have been inserted to better elucidate the text. The chapter on Technique has been enlarged, a description of the appendix and rectal valves added, and the entire chapter, as, indeed, the entire book, thoroughly and carefully revised. As did the first edition, the work in its present form stands as a model of what a student's aid should be; and we unhesitatingly say that the practitioner as well would find a glance through the book of lasting benefit.

Disinfection and Disinfectants. A Practical Guide for Sanitarians, Health and Quarantine Officers. By M. J. Rosenau, M.D., Director of the Hygienic Laboratory and Passed Assistant Surgeon U. S. Public Health and Marine Hospital Service, Washington, D.C. Illustrated. Philadelphia: P. Blakiston's Son & Co. 1902. Price \$2.00.

The general necessity for a work like the present is shown by the many times which physicians and others exhibit gross ignorance as to how and when to disinfect. The value of a work like the one before us is therefore self-evident, especially as it is based upon the well-known laboratory investigations of bacteriology. The facts stated in the book are concisely made, thus obviating the necessity of reading many words to obtain a few ideas. Controversies have been avoided, even at the risk of being dogmatic, and upon doubtful points the safer methods have always been given the preference. The subject has been considered from the standpoint of the disinfectant used and the object for which disinfection is done.

A Text-Book of Histology and Microscopic Anatomy of the Human Body, Including Microscopic Technique.—By Dr. Ladislaus Szymonowicz, A.O., Professor of Histology and Embryology in the University of Lemberg. Translated and edited by John Bruce MacCallum, M.D., Johns Hopkins University, Baltimore, Md. Illustrated with 277 engravings, including 57 plates in color and monochrome. Lea Bros. & Co., Philadelphia and New York. 1902. Price—.

The American edition of this work places in the hands of English-speaking instructors and students a text-book which includes the best results of recent investigations. The changes made in the German edition are mainly in the direction of addition. The author has traced throughout the development of the organs and the histo-genesis of the tissues, certainly an important standpoint for viewing histology.

As to the general make-up of the work, nothing can be any handsomer. The profuseness of illustration, and the great skill with which this work has been carried out, makes Szymonowicz's Histology an eminently practical work. The subject-matter presented is logically connected. The translation and editorial work having been done by one of the Johns Hospital staff of physicians is alone sufficient testimony of the value of the work, for anything medical having attached to it the name of that great institution is certainly of value, as is a piece of metal bearing the stamp of the United States Government.

General Paresis, Practical and Clinical. By Robert Howland Chase, A.M., M.D., Physician-in-Chief, Friends' Asylum for the Insane; Late Resident Physician State Hospital, Norristown, Pa.; Member of the American Psychological Association; Fellow of the College of Physicians, Philadelphia. Illustrated. Philadelphia: P. Blakiston's Son & Co., 1902. Price, \$1.75 net.

Certainly there is no form of insanity the diagnosis of which is more difficult in its early stages than is general paresis; and equally certain is it that no physician has had greater opportunities for its investigation and study than our author. We say this from a personal knowledge of his work and methods. The terrible consequences oftentimes ensuing upon the failure to recognize this disease in its incipency are many. It has been said that the general practitioner should not be expected to recognize these cases. But, in our opinion, he is the only one who has the opportunity for doing so. It is he alone who has the opportunity of observing the changes in character of the unfortunate patient. It is upon him that the family and friends depend for protection of their loved one. And yet we know that the subject is very largely ignored by just the men who should give it attention. Chase's General Paresis has been prepared with a view to the practical needs of the general practitioner and student of medicine with the view of laying before them as clearly as possible the special features of this strange disease. No attempt has been made to advance original views beyond giving the results of practical experience and research.

Diseases of the Stomach.—Their pathology, diagnosis and treatment, with sections on anatomy, physiology, chemical and microscopical examination of stomach contents, dietetics, surgery of the stomach, etc. By John G. Hemmeter, M.D., Philos. D. Professor in the Medical Department of the University of Maryland, Baltimore; Consultant to the University Hospital, and Director of the Clinical Laboratory; Author of a Treatise on Diseases of the Intestines, etc. With many original illustrations, a number of which are in colors, and a lithograph frontispiece. Third enlarged and revised edition. Philadelphia: P. Blakiston's Son & Co. 1902. Price, \$6.00 net.

With this work in its earlier editions we were quite familiar, having had occasion to make frequent reference to it when in quest of information concerning gastric disorders. The impression usually received at first sight of such large monographs is that they contain much that is not practical. Such is not, however, the case with Hemmeter's *Diseases of the Stomach*. Great attention has been paid to detail, and it is detail that brings success. The author's ideas are sound, and in many instances run contrary to those commonly held. For example, he is not by any means a strict adherent to the policy of feeding patients suffering from hyperchlorrhædia with animal food largely. On the contrary, he advances his experience to the effect that many such patients thrive on exclusively vegetable diet, and eventually make a perfect recovery. In this, the third edition, new material gleaned from medical literature since the appearance of the previous edition, has been added. The chapters on ulcer and carcinoma have undergone extensive revision, and there is a new article on gastric lipase.

The Diseases of Infancy and Childhood, for the Use of Students and Practitioners of Medicine.—By L. Emmett Holt, M.D., LL.D. Professor of Diseases of Children in the College of Physicians and Surgeons, Columbia University, New York; Attending Physician to the Babies' and Foundling Hospitals, New York; Consulting Physician to the New York Infant Asylum, Lying-in Hospital, Orthopædic, and Hospital for the Ruptured and Crippled. With 225 illustrations, including 9 colored plates. Second edition, revised and enlarged. New York: B. Appleton & Co. 1902.

The rapid advances of medicine have rendered necessary a general revision of this work, which has been carried out without any important change in the general arrangement. Nearly every chapter has been subjected to careful revision, and many of the chapters have been rewritten. As in the former edition the aim has been to supply every day needs of the physician who practices among children and the student who expects to do so. More space than usual has been given to pathology and the description of lesions, but this is because such knowledge is essential to a proper understanding of symptoms and diagnosis. Realizing from his own experience the great value of post-mortem observations in connection with clinical work, the author has introduced rather freely drawings and photographs of pathological conditions with the thought that they may in some measure supply the lack of these to the student.

The chapters on Milk and Infant Feeding have been entirely rewritten and much new material added. The introduction of weight charts adds greatly to the clearness of the discussion of the subject.

The "Preventive Medicine" Prize Essays.—The Maltine Company announces that two hundred and eight essays on "Preventive Medicine" have been entered in competition for the two cash prizes—one thousand dollars and five hundred dollars, respectively—which that firm offered last February. These essays are now in the hands of the three judges, Dr. Daniel Lewis, of New York; Dr. Charles A. L. Reed, of Cincinnati, and Dr. John Edwin

Rhodes, of Chicago, and their decision is awaited with great interest by the medical profession at large.

Personals.—Dr. Samuel F. Shannon, Denver, Col., removed to Sewickley, Pa.

Dr. F. B. Quackenbush, Hahnemann, '02, has located at 4700 Chester Avenue, Philadelphia.

Dr. I. E. Morris, Hahnemann, '02, has located at 810 Lake Avenue, Fort Wayne, Ind.

Dr. James A. Campbell, oculist and aurist, has removed to Rooms 206 and 207 Mermod-Jaccard Building, Broadway and Locust Streets, St. Louis, Mo.

Dr. Chas. W. Hakes, late of Nebraska, has located at Afton, N. Y.

Dr. D. W. Ensminger, Hahnemann, '02, has located at 427 Jackson Street, Philadelphia.

Dr. W. H. Carr has removed from Two Rivers, Wis., to Westport, South Dakota.

George W. Mitchell, M. D., Hahnemann, '02, has located at the corner of Gravers Lane and Germantown Avenue, Chestnut Hill. Office hours: 7.30 to 9.30 A.M.; 1 to 2, 5 to 7 P.M.; Sundays until 9.30 A.M.

Dr. George M. Cooper has removed to 1621 Chestnut Street—Chronic Diseases.

Dr. Wm. Morris Butler, of 507 Clinton Avenue, Brooklyn, N. Y., has returned from his vacation, and will be found in his office from 9 to 12 A.M. and 6 to 7 P.M.; Sunday 1 to 2 P.M.

Dr. J. Wyllis Hassler, lecturer on anaesthesia in the Hahnemann Medical College, met with a painful accident, on Sunday, September 7th, while returning from Mamaroneck, N. Y., where he had gone to etherize a case operated by Prof. Wm. B. Van Lennep. As the train neared the Philadelphia terminus the car in which Dr. Hassler was riding was struck by an engine, which exploded, allowing great volumes of live steam to pour into the rear compartment. Before the doctor could escape he was badly scalded about the face and hands. We are happy to state that he is rapidly convalescing.

Dr. Thomas L. Dedrick, Hahnemann, '96, of Washington, N. J., who had disagreements with Lieutenant Peary, the Arctic explorer, and left the expedition on August 27, 1901, arrived in New York September 21st. The doctor refuses to discuss his disagreement with Lieutenant Peary, but stamps the report of his being mentally unsound as "a malicious lie."

Dr. Howard M. Engle, Hahnemann, '96, announces the removal of his offices to 12 Geary Street, Starr King Building, San Francisco, Cal.

Dr. W. Nelson Hammond, Diseases of the Rectum, room 1018 Witherspoon Building. Hours: 9 A.M. to 1 P.M. Days: Thursday, Friday, Saturday. Other hours by appointment.

Dr. Maurice C. Ashley has been appointed Superintendent of the Middletown State Homœopathic Hospital at Middletown, N. Y. Dr. Ashley was born in Port Republic, N. J., in 1863, and has been connected with the Middletown institution for fifteen years past. In 1892 he was graduated from Hahnemann Medical College of Philadelphia, and was soon after appointed junior assistant physician at Middletown. He rose steadily from that position until he became the first assistant physician, and now, upon the death of Dr. Selden H. Talcott, he becomes the successor to that famous alienist. Dr. Ashley is an able physician, as well as a charming man, and a host of friends will rejoice at his selection as head of the first and greatest of homœopathic institutions for the treatment of the insane.

Messrs. Boericke & Tafel have in press a new work, "Diagnosis," by Dr.

Clarence Bartlett, from whose stenographic notes Farrington's "Clinical Materia Medica" was published, and who, later, wrote the neurological section of Goodno's "Practice." When published, this new work on medical diagnosis will constitute one of the largest, and certainly the most complete, ever published on that branch of medical science. It will include every important modern diagnostic fact, and will at once place the members of our school beyond the need of referring to old-school text-books on the subject, for they will have the best one in their own ranks. The book will probably run between 1000 and 1100 pages, and will have a most thorough index. Ready in October.

The Secretary of the Institute has left over a few copies of the splendid full-page pictures of the late Dr. Helmuth and of Dr. Talcott. Any member wishing to procure one for framing can do so by sending a request to Dr. Gatchell, 100 State Street, Chicago.

Practice and Property for Sale.—At Westminster, Md. Dr. D. F. Shipley wishes to retire.

Rochester News.—In accordance with the plans arranged by Dr. H. P. Bellows, of Boston, which have been tried in a number of the principal cities, the Monroe Co., N. Y., Homœopathic Medical Society have formed a proving club. Officers and examiners have been chosen as follows: *Director in Chief*, Dr. E. H. Wolcott; *Associate Directors*, Drs. H. W. Hoyt and W. W. Winans; *Special Examiners: Mind and Nervous System*, Dr. P. W. Neefus; *Eye*, Dr. E. J. Bissell; *Ear*, Dr. Thos. Parsons; *Nose and Throat*, Dr. H. W. Hoyt; *Chest*, Drs. E. R. Sumner and W. W. Winans; *Genito-Urinary System, Male*, Dr. N. M. Collins; *Genito-Urinary System, Female*, Dr. M. H. Ricker; *Skin*, Dr. T. D. Spencer; *Physiological Tests*, Dr. L. L. Button; *Blood and Bacteriological Examinations and Urinalysis*, Drs. W. A. Keegan and W. C. Daly.

Friday, September 5, the Examiners met at Dr. E. H. Wolcott's office to discuss plans, and to arrange their work systematically. This being done, work will progress rapidly and enthusiastically, as all have entered upon their several duties in good spirits, and desire to promote the matter with their best endeavors. Smallpox is practically stamped out in Rochester for the season at least, as there remains but 1 case in the isolation hospital at the present writing. In all there have been 142 cases between April 26, 1902, and September 9, 1902. Of these 17 have died, making a mortality of 11.97 per cent. Thirty-seven suspected cases were detained in quarantine, but did not develop the disease. Of the above total number of cases, 74 were of the discrete type, with 1 death; 64 were confluent, with 11 deaths; 5 were hæmorrhagic, with 5 deaths. It is estimated that about 110,000 persons were vaccinated during the past five months. Owing to lack of room in the main hospital building many of the patients were housed in tents. This, to the casual observer, seemed a somewhat rash procedure, as the weather during the fore part of the summer was wet and cold, but from the mortality and the opinions of the physicians it seems to have had a salutary effect rather than otherwise. The physicians in charge are loud in their praises of this method, as practically no medicines were given, aside from a little whiskey or strychnine for stimulants. In fact, several cases who were in the hospital proper improved immediately on being transferred to the tents. Two or three were expected to die at any time, and were removed from the ward for that reason. In another issue the writer hopes to give some interesting facts about the epidemic in Rochester, as well as about the isolation hospital which is under consideration.

W. W. Winans, M.D.

The Raue Medical Club of Central Pennsylvania.—The Raue Medical Club of Central Pennsylvania held its 19th monthly meeting at the residence of Dr. J. R. Humes, Hollidaysburg, Pa., August 5, 1902. The meeting was called to order by President Dr. Morrow at 3.30 P.M. The following members were present: Drs. Morrow, Sharbaugh, Baker, Blackburn, Taylor, Bohn and Hoy, of Altoona; Stitzel and Humes, of Hollidaysburg; Kessner, of Johnstown; also two visitors, Drs. Palmer and Kaufmann. A paper was read by Dr. Humes on "Puerperal Fever." The paper was interesting, and was followed by a general discussion.

Daniel Bohn, M.D.,

Secretary.

The Obstetrical Society of the American Institute of Homœopathy.—At the Cleveland meeting, steps were taken to complete the organization of the Obstetrical Society. As this society is entirely without means, a call has been made to all those who have signified their intention of becoming members to send two dollars toward defraying expenses, and a topic upon which they are willing to prepare papers, to the secretary, Dr. B. H. Ogden, St. Paul, Minn.

A Criticism of the Formaldehyde Lamp.—In a brochure, "The Formaldehyde," by Dr. Otto Hess, Chief Physician of the Medical Clinic of Marburg University, the author refers to the many formaldehyde generators which, depending upon the incomplete combustion of wood alcohol for the production of formaldehyde gas, have proved entirely insufficient. The author says, on page 49 of his book:

"The main reason for the failure of these lamps is that they produce far too little formaldehyde. According to Strüver and Brochet, only 5 to 10 per cent. of wood alcohol employed is changed to formaldehyde by the combustion, 90 to 95 per cent. of it being wasted as carboic acid and water.

"Another disadvantage of these lamps is the production of carbonic oxide gas, which is created by every incomplete combustion. The quantity of the same is, according to Brochet, 3 to 5 per cent. of the alcohol employed. Such a large quantity of CO gas in the air can produce disagreeable results."

Hot House Plants.—Refinement in matters of social life proceeds hand in hand with refinement in other lines as civilization advances. From the standpoint of the physician and of the anthropologist, it is a question whether the physical side of mankind is improving or degenerating.

The method of bringing up children, especially in the families of the well-to-do, is too often a serious menace to the child's health and development. Too much indoor life, too much supervision, too little freedom of motion and of will, is undoubtedly the cause of the many weaklings seen in the families of the wealthy. Such children have the characteristics of hot house plants.

The remedy is, of course, to do away with the surplus care and attention bestowed on the child, to let the child do more for itself, have more freedom, more fresh air, more play with other children. Foods and medicines are only temporary helps for child weakness. Such a medicine as Scott's Emulsion of cod-liver oil, or the hypophosphites, or some of the beef preparations, may be needed to give new strength and restore flesh; but nature is its own best doctor, and in the end can take care of "hot house children" if fond parents will only give nature a chance.

A Sick-Room Safeguard.—"I have never had a contagious disease spread where the patient has been isolated, and 'Platt's Chlorides' has been used. I have used the preparation for years, and it does the work so thoroughly that I look for no other." So says Chas. H. Howland, M. D., of New Haven, Conn.

A Mistaken Prognosis.—A prominent Boston physician recently was in attendance upon a child suffering with marasmus, that had been given up by himself and another doctor, they both agreeing that it could not live. As a last resort, however, the child was placed upon Eskay's Albumenized Food. The doctor was sent for four days afterward, and was so surprised that he hardly knew it. He said it almost seemed as though it had gained 20 pounds, it looked so different, and a thrush with which its mouth was covered had almost disappeared. It has since been kept on the Food, and is doing nicely.

Hanna and Hahnemann.—"One of my constituents who is down here from Spruce City made one of the funniest blunders the other day, apropos of Hanna," said Robert. "I gave him an idea of what he ought to see in the way of sights here in Washington, and, after I had taken him about in the Capitol and had introduced him to Frye and Henderson over in the House, I turned him loose to go sight-seeing. The next day he hunted me out of my Committee, and, after telling me how wonderful everything was, he hummed and hawed, and said, finally:

"But, see here, Senator, how about those three statues that are all bunched up together at Sixteenth and Massachusetts Avenue? I could recognize Webster and Scott, but who in thunder was the queer chap in the green clothes?

"Oh, the Hahnemann statue, you mean?"

"Yes, they told me it was a Hanna man; but who?"

This tickled the Senator, and I accused Robert of having made it up, but he insisted it was *bona fide*.

"And did you tell your unsophisticated friend," asked Senator P——, "who Hahnemann was? And that the wags about town have dubbed those three statues the three departments—Webster the Department of State, Scott the Department of War, and Hahnemann the Department of the Interior?"

"Oh, I made some feeble explanation, of course; but luckily my woolly Western friend rattled on about the impressiveness of Arlington. He did not need much enlightenment."—From "A Woman's Washington," in *The Saturday Evening Post*.

Antiphlogistine in Pneumonia.—The death-rate from pneumonia for the decade ending with 1900 is shown by the United States Census Bulletin of 1900 to have been greater than from any other one cause and 5 per cent. greater for the decade referred to than from the previous ten years. With such a large and increasing death-rate every physician owes it to himself and to his patients to test antiphlogistine, which has a well-earned reputation for being the best possible local treatment for this and other inflammatory diseases. Many physicians report that a single dressing, applied early, covering the entire thoracic walls and covered with a cotton jacket, will often abort the disease.

Sanmetto in Cystitis, Hypertrophy of the Prostate, and in Pre-Senility.

I have prescribed Sanmetto in my practice for a period of seven years, with the happiest results to my patients and great satisfaction to myself. In cystitis, true hypertrophy of the prostate, and where the complex generative system has lost its tone, vigor, and vivacity, it is the remedy *par excellence*. Many imitations are on the market, but the Od Chem. Co., of New York, makes the only Sanmetto.

J. M. Stukeby, M.D.,

Lancaster, Ohio.

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NOVEMBER, 1902.

A FEW THOUGHTS ON HOMŒOPATHY.

BY AUGUST KORNDORFER, M.D., PHILADELPHIA.

(Read before the Philadelphia County Homœopathic Medical Society, October 9, 1902.)

DURING the past few decades we have heard much criticism of homœopathy; its truths; its so-called fallacies; its assumed errors; its many shortcomings; its merits as a method of practice; its right to a place as a school of medicine. From the general tenor of these criticisms one might be led to infer that the fundamental truths first defined and expounded by Hahnemann had already served their purpose; that later discoveries had rendered them obsolete; and that time was now ripe for their subordination to a new order of things medical; in fact, that Hahnemann and his teachings were fit only to be relegated to some obscure place in history. One, prominent as a teacher, recently remarked, "Homœopathy is a dead issue." Yet this same physician has the audacity to hold membership in societies bearing the name!

But, *is* homœopathy a dead issue? Are its generic principles obsolete? Has the art and science of medicine advanced on lines so diametrically opposed to the law of similars as to give any reasonable ground for such assertion? To these queries every intelligent physician who has given thought to the subject must answer most emphatically, "No." In fact the very opposite condition obtains; every advance in medicine has brought the profession nearer to the acceptance of Hahne-

mann's teachings. The self-constituted critics and reformers who thus have endeavored to detract from the honor due the founder of homœopathy boast of their freedom from medical bias, and prate loudly of liberty of opinion and action; they nevertheless prove, by their methods, that they lack both the knowledge necessary and the perspicacity essential to just criticism.

We do not underestimate the value of criticism, nor the importance of liberty in both opinion and action; but when such liberty fails to be controlled by law it tends toward professional anarchism, and becomes a menace to the well-being of both patient and profession.

Nor do we underestimate the educational value of doubt. Doubt that acts as an incentive to philosophic investigation must be fostered. Such doubt never ends in unbelief; it leads on till dismissed by knowledge. Certitude is the very life of science, for science recognizes no tenable middle state between truth and error. Eclecticism, that middle-of-the-road method, which in medicine so often masquerades under the honorable title of homœopathy, has doubly wronged our school—actively, by implanting error; and passively, by discouraging real investigation. Eclecticism, strictly speaking, has no legitimate place in science. Its sphere is found in history and the philosophy of history alone.

Every honest searcher after scientific truth must recognize the necessity for law; and, as law obtains in every other department of nature's work, we, by analogy, must assume that medicine forms no exception. Here, too, law must reign. In the search for truth, methodical experiment guided by definite principles must in every case be our final court of appeal. Law must decide.

Hahnemann recognized this, and wrought with this thought ever in mind. It made the steps of his progress sure. With what confidence he appealed to the profession that they make experimental tests of all that he taught: "*Machts nach aber machts recht nach*" was the ground of trial and acceptance that he himself proposed. Test it, but test it accurately, and let it stand or fall in accordance with the response that nature thus will give. This was his challenge, and a hundred years of practice has proved him right.

Hahnemann was invariably right with his facts, and in his practical deductions from those facts; but when he attempted theoretical explanations the influence of the philosophy of his day necessarily manifested itself, and he ran more or less into error. However, of such explanations Hahnemann himself says: "I attach no value whatever to any explanation that could be given." "As this therapeutic law of nature clearly manifests itself in every accurate experiment and research, it consequently becomes an established fact, however unsatisfactory may be the scientific theory of the manner in which it takes place." He held the theory in the light of a non-essential.

On this point Hering, in the Preface to the American edition of the *Organon*, says: "Whether the theories of Hahnemann are destined to endure a longer or shorter space, whether they be best or not, time only can determine; be it as it may, however, it is a matter of minor importance."

Theories afford reason, means, for the discovery of the possible relationship between phenomena; through them working hypotheses are elaborated, and investigation thus facilitated; they prove useful, as aids, in the utilization of facts, and for this purpose their employment is not to be deprecated.

It is the bounden duty of the physician to thoroughly fit himself for his chosen profession through a comprehensive knowledge of the theory of medicine; this, however, does not conflict with the principle that "the practice of the art should be based upon the solid foundation of demonstrable facts."

In reasoning upon the relationship of observed phenomena, theories may be utilized as stepping-stones to legitimate conclusions; but in practice theories must ever be subordinated to facts.

Hahnemann set the example in his own life and work; we can do no better than faithfully follow the course he pursued. He deprecated theorizing, but not investigation and research; *a priori* conclusions, but not logical reasoning. He wrought, in full agreement with the axioms "Every phenomenon must have a cause" and "Every phenomenon must have a law."

His search for law necessitated theory, but he never permitted theory to govern the practice of the art. New modes of investigation and new fields for exploration were prompted thereby, but the discovery and establishment of the governing

law was ever the objective point. This is markedly illustrated in his search for the reason of his failure to cure chronic non-venereal diseases. In his "Chronic Diseases," Dresden and Leipzig, 1835, he refers to this, saying that since the years 1816 and 1817 he had been occupied in efforts to discover the reason why the known homœopathic remedies did not effect a cure in these chronic diseases. Continuing, he says: "After unceasing meditation, indefatigable research, careful observation and most accurate experiments, I was permitted to solve this problem for the benefit of mankind."

In this we have Hahnemann's method typically manifested. A fault discovered meant with him a search begun. All these years he wrought without expressing, even to his dearest friends, a thought upon this to him momentous question, "because it is unwise, yea, even harmful, to speak or write upon things yet immature."

That Hahnemann was not invariably right does not in the least affect the validity of the law that he discovered. Darwin, that great and independent thinker, surely erred in some of his conclusions; he also failed to perceive certain of the relations underlying the facts that he presented. Likewise, he failed to perceive their far-reaching influence in fields remote from those gleaned by him. Nevertheless, these failures to grasp every detail or to appreciate the full scope of his discoveries do not militate against the facts he discovered, nor do they invalidate any law that he legitimately deduced. Neither does Hahnemann's failure to correctly theorize lessen the value of his discoveries nor impair the utility of the truths that he taught.

It is worthy of remark that Hahnemann early recognized what in later years Spencer and other noted philosophic thinkers have even more forcibly expressed, namely, "that the reality existing behind all appearances is and ever must be unknown." He deprecated the search after such unknown, because *unknowable*;—never so, however, the search after facts, nor yet the rational effort at deducing legitimate conclusions from such facts.

To illustrate how our latter-day philosophy upholds Hahnemann's views in this particular, permit me to quote the following few sentences from Spencer: "If," says Spencer, "respecting the origin and nature of things, we make some assumption,

we find that through an inexorable logic it inevitably commits us to alternative impossibilities of thought; and this holds true of every assumption that can be imagined. If, contrariwise, we make no assumption, but set out from the sensible properties of surrounding objects and ascertain their special law of dependence, go on to merge these into laws more and more general until we bring them all under some most general law, still we find ourselves as far as ever from knowing what it is which manifests these properties to us."

"Ultimate scientific ideas turn out to be merely symbols of the actual, not cognitions of it." "The mind can conceive and consequently can know only the limited and the conditionally limited."

These views, concededly correct in other departments of philosophic research, apply just as forcibly to the search after the intangible in disease.

Hahnemann not only did not oppose the most exhaustive research, but, on the contrary, he set the example, and led the way in the most radical line of investigation ever instituted in medicine.

Recognizing the irrationality of a search after some hidden mysterious cause of disease, he confined himself to a critical analysis of the cognizable evidences of disease, namely, symptoms, signs and conditions discoverable by the physician, or appreciable by the patient or attendants. Had microscopy been an accessible means in his day, I doubt not he would have been one of the most ardent advocates of its use for diagnostic purposes. Illustrative of his critical research and wonderful powers of ratiocination, I will instance his views of the cholera contagium, published in 1831. His investigations led him to suspect the presence of a contagious material in cholera, which he described in the following words: "On board ships—in those confined spaces, filled with mouldy watery vapors, the cholera miasm finds a favorable element for its multiplication, and grows into an enormously increased brood of those excessively minute, invisible, living creatures, so inimical to human life, of which the contagious matter of the cholera most probably consists." Again, he speaks of "the invisible cloud that hovers closely around the sailors who have remained free from the disease, and which is composed of probably millions of those miasmatic

animated beings which at first developed on the broad, marshy banks of the tepid Ganges." With such prescient insight of the disease-producing factor in cholera, I cannot conceive of a man of Hahnemann's temperament giving up the search, or stopping short of the actual demonstration, save from a lack of suitable apparatus wherewith to conduct the investigation.

Generalizations, save as the logical outcome of individualization, he abhorred; therefore, while recognizing a specific organism as the germ through which such disease is propagated, he also recognized specific phases of its manifestations, and quite consistently contended for individualization in the selection of the remedial agent.

Each drug, to him, stood as the representative of a discrete totality, peculiar to itself; differing in some particular from every other such totality. It alone was indicated in certain given complexes of symptoms in given conditions of disease.

Hahnemann first clearly differentiated the three only conceivable modes of therapeutic drug action, and he first demonstrated the relative value of each. Logically extending his deductions, always guided and guarded by experimental tests, he arrived at a solution of the problem in the confirmation of the symptomatically similar drug action as the only positive guide to the selection of the curative drug agent. The law he reduced to the verbal formula, *similia similibus curentur*.

That Hahnemann pursued an exhaustive research before he gave the results of his labors to the profession cannot be disputed; that he came to his professional brethren with his new-found knowledge in full faith of their rejoicing and co-operation is beyond question; that his confidence met with ridicule and contumely, and that jealousy, hatred and persecution were his reward, is all too true. The principle of similars as a guide in therapeutics was derided. Elaborate and vituperative essays were written to show its absurdity and to defame its author; and, finally, the united political influence of physicians and pharmacists was employed in the effort to effect his professional ruin. Notwithstanding all which, he, during these years of persecution, gave to the world that masterpiece of medical philosophy, *The Organon*, and those monuments of indefatigable research, "The Materia Medica Pura" and "The Chronic Diseases." In all this work scientific exactness was aimed at, and to a marvellous degree attained.

The law of similars, the single remedy, and the minimum dose that will cure, were the three especial factors upon which he laid stress. But, in addition to this, we must not overlook the fact that a more consistent and intelligent study of pathology was urged, and the importance of the symptoms and signs of disease as guides to the selection of the curative therapeutic agent was emphasized. All this was so diametrically opposed to the teachings of his day that we can scarce wonder at the slowness of understanding manifested by his professional brethren.

Acceptance of Hahnemann's teachings by the old school has indeed been slow, but it has been sure. Every feature accepted has followed upon some independent research by members of that school. The importance of the symptomatic expression of disease; the recognition of the systemic involvement in even so-called local diseases; the improvement in and greater appreciation of hygiene on lines advocated by Hahnemann; and, last, but not least, the acceptance of Hahnemann's doctrine of the dual action of drugs, and the curative effects of small doses of drugs that in the healthy produce symptoms similar to those for which they are therapeutically prescribed, may be cited as among the most noteworthy. Closely allied to this latter should be noted their use of the nosodes in diphtheria, tetanus, typhoid, cholera, anthrax, etc. Many other changes are creeping in, which in the near future will bring their teachings upon therapeutics more nearly along the lines laid down by Hahnemann in the *Organon*.

The open advocacy of the dual action of drugs by the investigators in pharmaceutics of the old school marks an epoch-making event in medicine; for, with this fact once adopted, the barriers separating the two branches of the medical profession will practically be removed.

That such result will surely follow we have abundant reason to believe. In fact, it is already foreshadowed in such articles as those published in Merck's *Archives* of August, 1901, and May, 1902. In the editorial columns of the August number we read the following: "It appears to us that one of the problems to engage the attention of the twentieth century therapeutists and pharmacologists will be the action of drugs as influenced by dosage. This part of pharmacology has been

neglected entirely too much. There are hundreds of drugs whose action not only varies under different dosage, but it is diametrically different. Ipecac in very small doses allays vomiting; in large doses it excites it. Cocaine in small doses excites the reflexes; in large doses it depresses them. In the case of a number of drugs it will, therefore, be insufficient in the future to attach a label: depresso-motor, excito-motor, emetic, etc. The different action in different doses will have to be stated." In the May, 1902, number, the editor again calls attention to this fact, and quotes from the April *Medical Times* as follows: "This statement confirms what we have so often repeated, that the dual action of drugs should be taught in all medical schools, as then we should have not only an improved therapeutics, but also the annihilation of sects in medicine." "This question of dosage is the very foundation of the practice of medicine, and its solution and general adoption will prove the greatest boon to humanity. The physician who uses drugs only in larger doses, or in smaller, neglects one-half of the armamentarium which should be his. The indications which decide the dose are so diametrically different that it is easy for the student well versed in drug effects to apply his knowledge for the purpose indicated."

With such open acceptance of the curative action of small doses administered in accordance with the law of similars, we may confidently anticipate a still more general acknowledgment of the correctness of Hahnemann's views.

Thus, while some of the would-be leaders of our own school were adopting an apologetic attitude before the general profession, and were endeavoring to ape the methods of therapeutists who blindly denied the homœopathic law, the more advanced therapeutists of the old school were investigating, accepting and adopting the teachings of Hahnemann,—not, indeed, because they were of Hahnemann, but because they were of the *truth*.

This law of the neutralizing opposition of similars is so well recognized in other departments of physics that the opposition it has met in medicine is truly surprising. In the mechanical forces, in the sphere of dynamics, and in the psychic sphere, the same law holds. Is it not surprising, then, that in medicine it has aroused such violent opposition?

But, comes the query, do any of the later investigations in

pathology shed light upon this question? To this I unhesitatingly answer, Yes, and will call your attention to a few of the confirmatory facts recorded in some of the latest works upon this important department of medicine.

Prof. Roger, in his recently-published "Introduction to the Study of Medicine," says: "The antiseptics, properly so-called, when used in minute doses, have the very curious property of stimulating the activities of microbes; under their influence the chromogenic bacteria produce a greater quantity of pigment. On increasing the dose of the antiseptic, we see the chromogenic power diminish and disappear; then vegetations grow slower, cease, and finally the microbe is killed."

Again, "A good many of the *chemical substances*, including those known as antiseptics, diminish the resistance of the tissues and favor the development of microbes. So the tendency is in surgery to substitute, more and more, asepsis for antiseptis."

According to W. H. Thompson, "the effect of intravenous injection of peptone differs according to the amount of the substance which is introduced into the circulation; if less than .02 gm. per kilogram of body weight is added, coagulation of the blood is hastened; but if more than that amount is added, coagulation is retarded." A similar peculiarity with regard to their action upon coagulation has been noted by Horne in the case of salts of the alkaline earths. He found that though coagulation does not take place in the absence of a soluble compound of one of these elements, and though the addition of a small quantity hastens coagulation, the addition of a greater amount than .05 per cent. retards the onset of coagulation." Again, it has been noted that, "though the specific gravity of the blood falls after the injection of a large quantity of normal saline solution into the circulation, it nevertheless rapidly rises again, and does not cease to rise until it has reached a higher level than obtained previous to the injection."

I might quote at length from the published observations of investigators who not only had no interest in the demonstration of facts that support the deductions made by Hahnemann, but who really are in active affiliation with those who habitually deride both Hahnemann and his doctrines. Time, however, forbids; therefore these few quotations must suffice.

The results noted surely furnish warrant for the belief that educated therapists of all schools will ere long recognize in the law of similars a therapeutic law of nature, and in it find, as Hahnemann affirmed, the only available guide to a correct system of curative therapeutics.

The acceptance of the law does not, however, complete our work; many problems still remain unsolved. Among these may be mentioned a more exact definition or delimitation of its sphere of action; the discovery and demonstration of its corollaries, its concordants, and its related modifying forces, if such there be. For, although a law in its sphere is universal, it must, as a law of nature, act in harmony with other related laws.

Much also remains to be done in defining exact lines of demarcation between drugs having very similar pathogeneses; also, in determining some definite principles relative to the subject of efficient minimum dosage. This work can and should be carried on in our hospitals and colleges,—but it needs thinkers.

These and other features involved in the development of Hahnemann's discoveries, though secondary in importance to the great central truth, will nevertheless afford brilliant opportunity for research, and practically illimitable scope to the reasoning faculties of the scientific investigator in the field of medicine.

Physiology and pathology are lending efficient aid in solving these and other important questions. To investigators in these departments of medicine and to the painstaking work of the pharmaceutical chemist we may confidently look for many a happy solution.

Discussion as to the utility of the single remedy in comparison with the effects of polypharmacy is and has been occupying the attention of many therapists of the old school. At present, the single-remedy advocates number some of the brightest and most talented prescribers in that school.

The minimum dose remains an unsolved problem, being still in the empirical stage. Hahnemann's rule, *Organon*, §280, "The doses of all homœopathic remedies, without exception, are to be attenuated to such a degree that after their administration they shall produce an almost imperceptible aggravation,"

fails to define quantity or potency, and practically leaves the matter to be determined in accordance with the personal experience and individual judgment of the practitioner.

The subject of infinitesimals still arouses much discussion, though here the believer in the Hahnemann potencies is decidedly on the winning side. Fifty years ago and less, the mass of scientific men laughed to scorn the homœopath who expressed belief in infinitesimals; and even within the last two decades several learned investigators in our own school wrote lengthy essays upon the impossibility of getting curative action from even the twelfth decimal potency. Their argument was based upon the then accepted views of the atomic theory of matter. They argued that, as the atom is the smallest possible division of matter, and as the atom is a unit, simple and indivisible, therefore Hahnemann was wrong in his belief in the higher potencies. In refutation of this argument clinical facts were appealed to; but we were tauntingly told, "so much the worse for the facts."

Our learned friends' theses are still fresh in our minds, when behold! Science, that never respects persons or theories, ruthlessly upsets their learned reveries, and tells us that atoms may, indeed, as Dalton claimed, be "the only rational explanation of the laws of multiple proportion and combining weights;" but other and more recently-investigated phenomena make it probable that the atom "may in reality be composed of a great number of smaller parts." J. J. Thomson, from a study of the passage of cathode rays through gases, observed phenomena which led him to ask, "What are these particles of matter? Are they atoms, or molecules, or matter in a still finer state of subdivision?"

In explanation, Thomson speaks of these very small particles, or primordial atoms into which the molecules of gas are dissociated, as "corpuseles."

When we consider that the number of molecules in a cubic centimeter of gas, under normal conditions, may be six thousand million million million, and that each molecule is composed of two or more atoms, and that each atom may be composed of a great number of smaller parts, you may readily perceive that already the division is increasing to quite Hahnemannian proportions. And it doth not yet appear what it shall be.

DISCUSSION.

DR. DUDLEY: To say that I have enjoyed this paper is to give but very moderate expression to my real sentiment. The essay should be published and given a wide circulation. The essential medical truths embodied in the philosophy of homœopathy are recognized by a relatively small number of physicians and comprehended by few. By the members of the allopathic portion of the profession very little is really known of the subject. Allopathic authors who have written on it, without a single exception, so far as I am aware, have betrayed a lamentably dense ignorance of it in almost every paragraph; and those who profess to "have made a special study" of it exhibit even a more sublime lack of knowledge than do the others. But this is not the most unfortunate aspect of the case. Many of those who honestly think they are practicing homœopathy have simply employed its methods in accumulating a fund of clinical experience and indications, and are now using their remedies on the basis of this "experience," just as the crudest and most unscientific allopath uses his, but with this advantage: that, having thus provided himself with a far better armamentarium than his allopathic brother, he attains a higher degree of success. He is prescribing medicines that are often measurably homœopathic to the case; but as his choice of a remedy is determined solely by his experience, and not by the natural law of similars, he is not practicing homœopathically. This prescribing on the "clinical indication," as it is termed, is frequently reported from homœopathic clinics in our journals, and the prescribers seem, in some instances, to take actual pride in what they ought to regard as a confession of ignorance.

The author of the paper undoubtedly states the truth when he says that some think that, while the Hahnemannian doctrine may have served some good purposes in its earlier days, its truths are now no longer useful, because of the advent of other forms of knowledge. The argument is of a piece with the mode of attack leveled against the great moral and religious truths of our time. As though a doctrine of science could be true to-day and untrue to-morrow! Homœopathy a "dead issue"? Not till diseases shall no longer exist or drugs

shall cease to act; not till gravitation, and heat, and chemical affinity and life shall cease to operate—not till then will the truth of homœopathy be one whit less true than it was when the Author of Creation ordained it. The “question” whether homœopathy is a dead issue is *not* a question. The only real question is, How can any physician be so unacquainted with the facts of nature as not to know that homœopathy is true, and that it always will be?

One of the medical sects of the day has gone so far as to declare, in its code of ethics, that not only has the law of cure not yet been discovered, but that if it ever should be, the members of their societies shall not be permitted to use it in their practice, nor shall their patients be allowed to enjoy the comfort or the safety to life that might result from its employment. Such is the meaning of the allopathic code of ethics when its significance is fully understood, and such is the attitude of the allopathic profession toward both a present and a possible science of therapeutics.

Argyll says “The search for laws is the great quest of Science, and the finding of them is one of her greatest rewards.” Yet medicine presents a spectacle of men who study therapeutics, who believe in therapeutics, who rely upon therapeutics, who practice therapeutics, and who insist upon being considered scientific practitioners of therapeutics, who at the same time declare that there is no such thing as a science of therapeutics, and that there never will be.

A word respecting the curious statements recently made by the distinguished editor of Merck’s *Archives*. This statement, as quoted by our essayist, is a rather pronounced echo of numerous suggestions and innuendos that have been floating on the stream of medical journalistic literature for quite a long period,—the doctrine of the duality of drug-action. This doctrine, though scores of years old, is new to our allopathic friends; at least they talk about it as something recently brought to their notice. According to its teaching, any drug, administered in a small dose, should be capable of exerting remedial action upon a condition similar to that which it is capable of producing if given in a large dose. Merck’s editor is apparently oblivious to the distressing fact that he is riding roughshod over one of the most cherished doctrines and

dogmas of his own school, namely, that there is no such thing as homœopathy, and that there never will be, and never shall be, world without end. Amen! We, however, know that to declare the duality of drugs is but another way of declaring the truth of homœopathy. The one doctrine involves the other with the certainty of a mathematical proposition.

This, however, is not the principal aspect of the matter. If the duality of drug-action as Merck's journal has stated it,—and no well-educated physician, certainly no homœopathist, will deny it,—it would seem that homœopathic practice based on this duality ought to be carried on with small doses of drugs which had been proved with large doses, or *vice versâ*. There is not the slightest doubt that a successful homœopathy could be, and perhaps is, to some extent, practiced on this basis. But such is not the basis of the homœopathy that Hahnemann taught. He taught that not only do drugs exert a dual action when exhibited in both large and small doses, but that any effective dose, either large or small, will cause two sets of phenomena, denominated action and reaction, or primary and secondary actions. Our allopathic friends have not yet perceived the practical value of this physiological fact, but they will in time. Let us be content to wait yet a hundred years or so. Large, and especially old, bodies move slowly.

T. S. DUNNING, M.D.: Man started out with no innate knowledge of nature's laws, nor had he any revelation with regard to them. His knowledge began with observation. Facts accumulated, and from a multitude of facts he began to generalize and theorize. One theory after another arose, only to be given up. It was not until the severe inductive method was adopted that science began to have a true basis and the laws of nature began to be formulated, so that there was a true basis for calculations and for predicting an effect from a cause. This method is the only true one.

Hahnemann applied the inductive method in studying therapeutics. He claims to have found the law of similars to be the only explanation of cures of diseased conditions by drugs. Is he right? Is that the law of cure?

Dunham says: "The physiological school scoffs at a therapeutic law because a law of this kind is empirical and does not

rest on a rational understanding of the causes of disease. And this is true. It is likewise true of physics. The laws of the attraction of gravitation, of the diffusion of light and of chemical affinity in definite proportions are empirical laws. They do not rest on a rational understanding of the causes of the natural phenomena with which they deal respectively; for, in truth, we know nothing about the causes of these phenomena, and have never been able to find out anything about them. These laws are simply inductions from a multitude of observed facts. But the physiological school undertakes to find out the causes of the phenomena of disease; to trace the symptoms of disease back to their remote origin; and then, acting on the general principle, 'remove the cause and the effect will cease,' to remove the cause and thus cure the disease."

He then states that in hygienic measures for the prevention of disease this can and should be done; but in therapeutics there is no means of knowing the cause of disease.

Even now we are still bound in our knowledge of the cause. Although the germ theory is largely accepted, there are many who doubt whether the germ is not rather the concomitant than the cause.

Again, while we are destroying the germ, may we not destroy the individual upon whom the germ lives?

Germicides have their place outside the body. The anti-toxins are limited in their application and efficiency.

We still want to find out a law of cure. We believe Hahnemann promulgated and demonstrated such a law. We have demonstrated its truth to our own satisfaction again and again.

Some months ago a lady of a rheumatic diathesis complained of scaling, cracking, with fissures of the finger ends. Small vesicles would form, and then exfoliation of the epidermis would take place. She had been free from any sign of eruptive diseases until recently. There had been severe and annoying backache, but there was no sign of sugar, albumin or casts. There was at times excess of urates.

This case was treated with rhus, graphites and mezereum, with varying success. Then ichthyol ointment was added, with temporary improvement in the hands. In the meanwhile the roughness and harshness of the skin had spread to the breast, shoulders and thighs. There had been several abscesses on

arms and in axilla which received surgical dressings. After some months, when the patient was in despair, and I, also, *rhus tox.* 1x was given for a few days, and other measures were given up. The improvement was marked on her return to the office, and a placebo was given. The improvement has continued and the patient is nearly well, after about three weeks. *Rhus* is one of the remedies where repetition spoils the case. It should not be given too low. I remember an instance illustrating the great susceptibility to the action of this drug. Dr. Hunt, a former surgeon to the Pennsylvania Hospital, was absent from clinics for several weeks when I was in attendance there. When he returned he said, "Gentlemen, I have been to the country."

The proofs of the truth of a natural law are not found in any analogy that may be traced in some other domain of nature, nor are they determined *a priori*.

We must come to the final test, "Does it work?" Does it accord with the observed facts?

The working of one law does not prove another. Yet in studying Nature to determine her laws in any one direction we constantly find other principles coming in. Some other principle limits the action of the law. The law of gravitation acts everywhere and an unsupported object falls to the earth, if near it, yet the power of our arm lifts an object; the attraction of a strong magnet lifts a bit of iron, and for the time the law of gravitation seems in abeyance; but no one who sees the magnet and knows its power thinks that. He only realizes that another law is working; and, within its limit, for that object and kindred ones, it is stronger. The same law tends to draw the earth and its kindred planets to the sun, and yet they do not fall into it because of the impetus that they have already, and the tendency to fly away into space. One force controls or modifies the other, and thus each planet keeps its orbit, and there is no disorder or confusion. Thus we find one quality and law of nature modifies another.

The same thing is true when we come to study the human organism. There are physical and chemical laws that constantly come into play, while over and beyond these are the laws that apply to the life force. This law of the similars is nature's law of cure.

DR. E. H. VAN DEUSEN: Knowledge of a single fact not known as related to any other fact, or of many facts not comprehended under any general law, does not reach the meaning of science. Science is knowledge reduced to law and embodied in system.

From what we know already, we are led to believe that all facts are scientific; that all forces are correlated. There are many facts for which we have not yet been able to formulate a law, which we have not yet been able to embody in a system, but we have arrived at a stage of belief where we feel convinced that when facts appear isolated it is only because we have not acquired a knowledge of their associated phenomena, and not because such association does not exist.

Is there any conceivable reason why therapeutics should be excluded from the domain of this general principle? Chemistry, physiology, pathology, anatomy, physics, are sciences. We do not think of discovering facts in any of these branches that are independent, but we immediately search for their position in the general economy, with full faith that there is a place for everything; that there is nothing superfluous, and nothing omitted.

Why should intelligent, educated, masterful physicians look upon drug therapeutics as simply a mass of isolated phenomena with no relationships except those existing between individual drugs and individual diseases? Physicians of the dominant school seem to have abandoned all effort, and even thought, of embodying the relationship existing between drugs and diseases in any system. They, in effect, deny the existence of any law governing the application of drugs to disease. Their most intellectual and capable men in the centres of medical thought are skeptical of the curative action of drugs, and use them chiefly for their mechanical effects.

Two exceptions to this rule stand out like obelisks upon an arid plain: quinine for malaria and mercury for syphilis. One is the stone from which Hahnemann stepped to the heights of homœopathy; the other presents a picture so suggestive of the homœopathic principle that it would seem impossible for even educated intellectual bigotry to turn aside from a careful investigation.

Such an investigation would illuminate the great fact that

there is no known therapeutic law except the law of similars; that there is no embodiment of therapeutic facts in any system except that of Hahnemann; that homœopathy is the only known scientific therapeutic principle.

G. W. SMITH, M.D.: My sentiments are those of the author. Science, strictly speaking, is systematized knowledge; it is truth, with the collection and arrangement of facts to prove it, and in this sense Dr. Korndørfer's paper is a thoroughly scientific paper. Dr. Hahnemann proved the existence of the law of similars in medicine, and exerted all the powers of his great mind, indefatigable energy, inexhaustible research and fine analysis for the elaboration of this great truth, with the result that the attention of a number of the brightest intellects of his day was attracted, and after careful study these men finally accepted, believed and practiced in accordance with this principle. There were skeptics and critics then as well as now,—men who regarded this system as unworthy of belief, as being contrary to common sense. They ridiculed Hahnemann and his followers; but ridicule is not argument. During all the years since the first utterance of the teachings of Hahnemann, homœopathy has continued to be believed in and practiced. Certainly not all these followers have been either fools or liars; and if such is the case, there must be some truth in homœopathy. Dr. Korndørfer states that it is claimed by some that homœopathy is dead and its practice obsolete; and then goes on to prove that it is a science based upon a proven law. A law always continues to exist, and never becomes obsolete. Hahnemann proved it to be a universal law in medicine; and if as such it existed then, it must exist now and always will exist. Diseases may change, and theories of diseases are changing constantly. Those who base their practice upon these theories of disease are, in consequence, being constantly led into error. But the patient suffering from disease always has symptoms of suffering, and prescriptions based upon these symptoms are founded upon a scientific basis, and will succeed regardless of all theories concerning the causes of disease or the pathological changes that may take place therefrom. Dr. Korndørfer tells us that Hahnemann recognized the irrationality of trying to discover the mysterious cause of disease, and so applied him-

self, instead, to a critical analysis of the cognizable evidences manifested by disease, viz., symptoms, signs and conditions as observed by the physician and experienced by the patient. By relieving these conditions he could relieve the patient, and by the application of medicine according to the law of similars this was accomplished.

In conclusion, let me say that such papers as the one we have just listened to always do us a great deal of good, and if we could only hear many more, we would all be much better physicians and more worthy of the great trust that is committed to us.

T. H. CARMICHAEL, M.D.: Mr. President: I enjoyed the last part of this paper much more than the first. I take exception to the statement that we are obliged to practice according to a dogma. In the first place we are scientific men, and as such have the scientific mind, which holds dogmas only tentatively. The law of gravitation would be discarded to-morrow if some other statement better explained the facts. As scientific men, we have a right to anything in medicine. I object to being put on the same plane with osteopaths and faith curers, because they are not physicians by education, and are not so recognized by law; they are necessarily limited to just what they profess. The paper says a great deal about the rights of patients, but physicians have rights also. The truth of the matter is, that to cure the sick is an art, and not a science, and a physician is usually selected because of belief in him as an artist who can successfully apply remedies in a given case. We hear much about the *science* of medicine; and yet one may know all that is known of some of the sciences that enter into medicine and yet be comparatively unsuccessful in the *art* of applying remedies for the cure of the sick.

I would be consistent for a higher reason than the legal one, because I believe that homœopathy furnishes the best method of applying the healing art. Hahnemann was a great artist, but, just as in painting or sculpture one cannot be a Michael Angelo, so we can but strive after the efficiency of Hahnemann. The best results follow the use of his methods; outside of these, almost the same chaos prevails at the beginning of the twentieth century as existed when he first announced the law of cure.

DO WE OPERATE EARLY ENOUGH IN APPENDICITIS?

BY WILLIAM B. VAN LENNEP, AM., M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, Sept. 24, 1902.)

THE negative answer which I believe should be given to this question may be more readily accepted when I confess that I have more than once been guilty. During the past fifteen years, intimately as I have been associated with the development of the treatment of this dread disease, and conscientiously striving as I have to reach a safe conservatism, I am satisfied that I have stood by and allowed more than one golden opportunity to pass. And so have most of us—at least that is what the most experienced medical men tell me, and that is what I find in a goodly proportion of the cases to which I am called in consultation, or which are brought to me for operation.

Why, then, should we not operate every case of appendicitis as soon as it is recognized? Such a rule is undoubtedly the *safe* one, and would materially decrease the present mortality-rate; in fact, I have been gradually forced to the conclusion that the only excuse for not operating during distinct attacks is to wait for the safer “interval operation.” With this conclusion goes another one, which I believe I am in a position to state without being accused of selfish motives, and that is that once diagnosed, and the sooner this is done the better, appendicitis ceases to be a medical disease—it is as distinctly surgical as bowel obstruction, strangulated hernia, head injuries, complicated fractures, extensive wounds, etc.; and to these should be added gall-stone colic and cholecystic disease, renal colic, and kidney enlargements or displacements. We are even hoping to help you out in those bugbears of internal medicine, Bright’s disease and cirrhosis of the liver.

This is not merely the conviction of a surgeon, or, to be more impersonal, the consensus of surgical opinion, but it is fast getting to be the opinion of the intelligent laity who demand operation during attacks as soon as the disease is diagnosed, or, in case of recovery, “interval operations,” to prevent a recurrence; and, what is more, if it is not recognized before

complications set in, they want to know why the case was operated too late. We certainly cannot allow this same intelligent laity to show us the way; and I might add, with all due delicacy, that ethics will often care for one and protect one, but that the intelligent layman is not bound by the laws of medical ethics. It would seem, then, that the logical duty of the general practitioner is to arrive at a diagnosis, and that at the earliest possible moment, in order to avoid the complications which so often supervene with astounding rapidity; to recognize this, as any other surgical disease, in time to "deliver the goods" in good condition to the surgeon. Here the practitioner's duty ends; and this is all his duty and all his sphere in appendicitis, in gunshot-wounds of the abdomen, in contusions and compressions of the brain, in fractured skull; in short, in all that long list of conditions which our forefathers were wont to temporize with, but which we recognize as belonging to the life-saving surgery of the present day. If we can read correctly between the lines, or interpret correctly the dribblets that have leaked out through the censored bulletins, King Edward had but an unrecognized attack of the "American disease;" saving his own life, as most old people do, by walling off the infection, and finally enabling his physicians to recognize that the "lumbago" meant *appendicitis*; the "chill," *pus*; and to open a simple abscess, a localized fibrino-purulent peritonitis. How often have we been as fortunate! In an article read before the Pennsylvania State Society in 1895 I reported one hundred and three operations for appendicitis, of which seventy-eight were carried out during attacks. Of these, there were but six which presented no extra- or peri-appendiceal lesions; the remaining seventy-two were therefore operated too late, and but for kindly *Dame Nature*, or unexpectedly successful surgical measures, they were necessarily doomed.

Such statistics cannot but appeal to the reasoning mind, and they are corroborated by the increasing experience of physicians, with the exception, perhaps, of those who have been blessed with an unusual run of good luck. I say *good luck* advisedly, for practitioners have told me that such a run has so changed as to lead them not only to change their opinion, but also to retract their previous public statements. For the same

reason I find one physician after another who prefers to have ten people recover from attacks without operation in the hospital, with surgical aid close at hand, than to take the chances of sending one in too late; and the majority of the former patients will readily assent to or even ask for an interval operation after recovering from the attack.

In connection with this same question there is another conclusion to which I have been largely led by my medical colleagues, notably Dr. Goodno, and that is the underlying influence of what I may term, for the moment, "latent appendicitis" upon that long list of conditions usually supposed to be dependent upon disorders or displacements of the stomach, intestine and colon. Dr. Horace Packard, of Boston, in a scholarly article read before the Surgical and Gynæcological Association of the American Institute of Homœopathy last June, advances the theory, and supports the same by logical arguments, that the human appendix is undergoing a process of involution, not only in the individual, but also in the race. Such involution, when starting at the distal end and working toward the cæcum, may result in complete obliteration (probably the so-called "appendicitis obliterans"). Beginning in the proximal end, however, retention, distention, anæmia, infection, gangrene or rupture must follow sooner or later. This process of involution he considers less advanced in America than in Europe or the Orient, and he believes the time will come when the disease will become less frequent here as well. While we may not accept the conclusion that the appendix will ultimately disappear from the human organism, and while we may not be willing to carry preventive surgery to the extent of indiscriminately removing the appendices of all children, thus adding the *sans*-appendix to the *sans*-præpuce sects, I am satisfied that there can be a premonitory stage of appendicitis, or a stage of "appendiceal involution," during which refractory abdominal disturbances are produced which are cleared up by the removal of the organ. Appendiceal irritation in an organ which is emptying itself with increasing difficulty may not set up inflammation enough to give rise to the pathognomonic tenderness; but, like ordinary "cramps," it may produce the characteristic, primary, "referred" pain of all abdominal obstructions to the epigastrium or umbilicus. Years ago the

observation was made that, in tying off an appendix during an operation under local anæsthesia, intense pain was felt exactly at the umbilicus. Pain, and even tenderness, to the left of and above the umbilicus I have so frequently observed during attacks of appendicitis that I have come to look upon it as a strong corroborative symptom. So, too, is this a strong suggestive symptom in obscure abdominal disturbances, pointing to an *involuting* appendix as the cause.

Let me cite a couple of illustrative cases:

1. Several years ago I saw a colleague who was practically invalided by digestive derangement, the prominent symptom being a distinctly localized pain above and to the left of the umbilicus. I could not explain the cause, and even went so far as to suspect malignant disease of the splenic flexure or descending colon. Last winter he developed a long and severe attack of appendicitis, and in the interval following I removed his appendix. Together with the distinctly appendiceal symptoms, the left-sided pain and intestinal derangement disappeared. His appendix pointed outward, *i.e.*, to the right.

2. Early in 1899 I saw, with Dr. Marsden, an anæmic young girl who had, to a marked degree, not only the above-mentioned left-sided pain, but a distinctly localized tenderness, which strongly suggested gastric ulcer in a sagging stomach. She became a confirmed invalid; in fact, a neurasthenic; and finally, while undergoing a "rest cure," Dr. Goodno discovered a tenderness at the McBurney point as well. On removing the appendix last winter, we found it apparently congenitally stretched across the abdomen to the left for five or six inches. It immediately contracted to an inch or less when released. She is in perfect health to-day. It is unnecessary, I think, to multiply examples.

One more thought and I am done. We are all familiar with the frequently associated enteroptosis in movable kidney; also with the fact that mere nephropexy will not cure the intestinal sag, and therefore the symptoms of the same. I have seen a number of cases with Dr. Bartlett, in connection with his stomach work, which have convinced us that the appendix here, too, plays an important rôle. Given a distinct gastrectasis, or a transverse colon hanging down into the pelvis, and the chances are that kidney fixation will only relieve the renal distress; but it is

well-known fact, and I have had abundant corroborative proof of the observation, that a displaced kidney is sooner or later followed by appendiceal disease. This has been usually attributed to interference with the return flow of blood through the superior mesenteric vein, although it might also be laid at the door of the associated caecal sag and the consequent appendiceal kinks. A combined or consecutive nephropexy and appendectomy have again and again relieved all the symptoms, renal and intestinal, even in the presence of a moderate enteroptosis.

To sum up :

1. Appendicitis is strictly a surgical disease.
 2. Even at the present day a large proportion of operations during attacks are undertaken too late.
 3. Interval operations are safer, and are, therefore, the only excuse for delay in the majority of cases.
 4. Many obscure gastro-intestinal symptoms are dependent upon what we might call, for the want of a better term, an "involuting appendix," and disappear after the removal of the same.
 5. While tenderness at the McBurney point is the pathognomonic symptom, epigastric and umbilical pain, as well as the left-sided pain, or even tenderness between the umbilicus and the spleen, are very strongly suggestive.
 6. Movable kidney is often but a part of a gastro-enteroptosis, and therefore its fixation does not relieve the symptoms due to general sagging. In many cases, however, the symptoms of renal distress are relieved by nephropexy, while the abdominal symptoms disappear after the removal of the appendix upon which they are dependent.
 7. It is the duty of the expert medical diagnostician to differentiate the underlying cause in these obscure cases, and to have them cleared up by the appropriate operation.
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CLINICAL LECTURE ON A CASE OF HYPERCHLORHYDRIA.

BY CLARENCE BARTLETT, M.D., PHILADELPHIA.

(Delivered at the Hahnemann Medical College of Philadelphia, October 6, 1902.)

TO-DAY we have before us a patient who has been ailing for a number of years. As I give you his history, you will observe that the course of his illness may be divided into two parts. In the first period, which began seven or eight years ago, the symptoms appeared to be almost entirely of a neurotic character; during the past eight months they were strongly suggestive of the presence of an organic disorder. Our patient regards himself as a dyspeptic. This word is decidedly objectionable, because of its past associations. It means nothing excepting disturbed digestion. For years we have been accustomed to hear it referred to a class of uninteresting cases which we do not take the time to diagnose correctly. I wish you to disabuse your minds of the idea that dyspepsias are uninteresting; on the contrary, they are, if studied properly, of great interest from both diagnostic and therapeutic standpoints. Recent methods in the examination of gastric disorders make the diagnosis a matter of comparative certainty, though obscure cases will arise from time to time. A good example of such obscure illness was found in a patient whom I saw with Dr. Campbell, of Woodbury. The patient, a woman of sixty years, suffered from abdominal pain, vomiting and tumor. The latter was in the orthodox position for pyloric carcinoma. But, strange to say, it disappeared after the act of vomiting, the ejected material consisting of nothing but bile. The patient was sustained entirely by rectal alimentation. It was suggested that the tumor was a distended gall-bladder; but such a theory was untenable, for vomiting could not possibly cause a collapse of its cavity. The idea I had of the case was that we had a tumor of the stomach, which was palpable with the stomach partially distended, but got out of the way when the organ was emptied. The patient died, and the autopsy showed the cause of this strange state of affairs. There was a cicatricial stenosis of the duodenum below the entrance of the bile-

duct. The previous history of the case gave us no data from which to deduce the existence of the duodenal stenosis or causes leading thereto.

Our present patient gives a fair family history. One sister died of pulmonary tuberculosis, and he has two sisters and three brothers living and well. His illness began about eight years ago, when he complained of considerable distress in the epigastrium. After continuing for about three or four weeks it passed off, and he continued well for a month or so. Then there was a recurrence. And so the trouble has continued ever since. At times he was so uncomfortable that he remained away from his work, and occasionally took to his bed for a few days at a time.

Eight months ago the distress or discomfort gave place to actual pain, which came in paroxysms. They do not seem to be influenced in any regular way by eating, for sometimes they are worse just before eating, and sometimes an hour or so afterwards. He frequently has vomiting, and this always relieves the pain.

Before proceeding with my analysis of the case I will make an examination of the gastric contents. The patient was given a test-meal about an hour ago, this meal consisting of half a pint of tea without sugar or milk, and a roll without butter. To remove his gastric contents I make use of a short stomach-tube. You will observe that it has no bulb. I find that the plain tube is just as efficient as the other. In the few instances in which I have failed to obtain gastric contents by expression, I have also failed with the bulb. I introduce the tube, as you see, but with all the care I take, no contents are ejected. We will therefore make use of the suction bulb. We fail in this also. Withdrawing the tube, I see within its lumen some of the gastric contents, which I see on measurement to be 5 c.c. This will enable me to make a rough estimate of the quantity of free hydrochloric acid. To do this I place the contents in a beaker with a drop of Topfer's solution, which you know is a one-half of 1 per cent. alcoholic solution of dimethylamidoazobenzol. Immediately there appears a rose-red reaction, showing the presence of free hydrochloric acid. I now proceed to titrate this with a decinormal solution of sodium hydrate, until finally the latter neutralizes the free hydrochloric acid, and the

red reaction with Topfer's solution disappears. I find, upon looking at the burette, that I have used 3.5 c.c. of the sodium hydrate solution, and this was on 5 c.c. of gastric contents. To have neutralized the free acid in 10 c.c., we would have required 7 c.c. of sodium hydrate. The total quantity of free hydrochloric acid is then represented as 70. Normally, it should be 40. We have therefore a hyperchlorhydria.

We may now proceed, if we have the time, to determine the total acidity by adding a 1 per cent. alcoholic solution of phenol phthalein to the gastric contents, and continue to add the sodium hydrate solution as before. As each drop of alkali enters the mixture there is a reddish reaction, which disappears on shaking or stirring. Finally there comes a time when we observe that the red reaction is permanent. This shows that the total acidity of the gastric contents has been neutralized. The amount of sodium hydrate thus used, plus that previously added to determine the total of hydrochloric acid, multiplied by 20 (because in this case but 5 c.c. of gastric contents were used), gives us the total acidity. The practical point in this case, however, has been determined, namely, that free hydrochloric acid is greatly in excess of the normal.

I now proceed to explain the symptoms of our patient. The symptoms presented by him for so many years are the ones we usually find in cases of hyperchlorhydria, consisting, as they did, of vague epigastric discomfort, oftentimes sufficiently severe to cause great suffering, and associated with general nervous instability. We need not, therefore, make any remarks concerning them.

But in the past eight months the phenomena have been of an entirely different character. The patient has actual pain. How are we to explain this symptom? Naturally, we think of the various gastric affections capable of giving rise to pain. They include cancer, ulcer, and gastralgia. Is there any possibility of this case being one of cancer? Such a hypothesis is not to be thought of as possible, with the history prior to eight months ago. But remember, it is not so very uncommon for cancer to be engrafted on some previous gastric disturbance. In gastric carcinoma the hydrochloric acid secretion is lost entirely; occasionally it is only diminished; rarely it is normal; and practically never is it in excess. We are therefore safe in eliminating cancer.

Ulceration is not to be thought of, for in none of the vomiting paroxysms which this man has had has there been ejection of blood, and the aggravation of the pains is not in keeping with that observed in ulcer. In ulcer, however, it is common to find increased hydrochloric acid percentage. The pains are distinctly paroxysmal, there being weeks of freedom from them. This we are not likely to find in ulceration.

As to gastralgia, this is an affection whose existence must be regarded as theoretical rather than real. By this term we mean a gastric pain dependent upon nervous causes, occurring independently of changes in structure. To my mind such a state of affairs is impossible. But clinical conditions to which the term may be conveniently applied can exist, and this case is one. Let us suppose, and this is probably the case, that the hyperchlorhydria acts as an irritant of the gastric mucous membrane; that a spasm of the pylorus follows. Pain is a not unnatural result.

To sum up, this is a case of hyperchlorhydria which has gradually gone from bad to worse, until now pyloric spasm has become part of the condition.

The practical question is the final one. What shall we do with him? Opinions as to the dietetic management differ. The prevalent method favors a diet consisting very largely of nitrogenous food, the idea being that such food will neutralize the excess of acid. And such, indeed, is the case, and relief does follow. But, on the other hand, nitrogenous food is an important stimulant of hydrochloric acid secretion, so that, in the long run, the trouble is actually increased by its administration. On the other hand, when we use a purely vegetable diet the stimulation of the gastric mucous membrane is at a minimum, less hydrochloric acid is secreted, and ultimately our patient is improved.

Laboratory investigations have demonstrated that fats inhibit hydrochloric acid secretion. Clinical experience demonstrates that we may use this information with advantage. We have the patient take butter in as large quantities as he can,—as much as four ounces daily. This does good not only by inhibiting the acid secretion, but also as a fatty food. Nervous patients thrive on a diet into which fat enters largely. Patients with hyperchlorhydria are generally neurotic. So butter is good for them in a double way.

So far as medicine is concerned, this patient has been taking atropia in doses of $\frac{1}{200}$ of a grain three times daily. Atropia is beyond all question an excellent palliative in this disease, but it does not cure. Some few patients are annoyed by the mydriasis and dry throat which it causes.

So far as curative medicines are concerned, but little can be said. I have never seen any results of which I was sure. Results have been claimed, but, so far as I know, have not been backed by gastric analyses, and other measures have been employed. Thus it was impossible to say how much was due to medicine, how much to general measures.

The mode of life of the patient is oftentimes of the highest importance. Outdoor life and freedom from worry will accomplish wonders. It is, indeed, astonishing to observe some of these patients, when away from home and business cares, on a vacation, partake freely of food that would tax the digestion of one of the lower animals, and maintain an easy, happy disposition day after day. For some time after their return to their usual haunts and vocations will this period of good health continue. Then nerve-tire comes on, and with it disturbed gastric secretion.

THE SURGICAL TREATMENT OF POSTERIOR DISPLACEMENTS OF THE UTERUS.

BY THEODORE L. CHASE, M.D., PHILADELPHIA.

(Gynæcologist and Obstetrician to Hahnemann Hospital; Gynæcologist to West Park Hospital.)

WITHIN the past few years there has been a wide difference of opinion among gynec surgeons as to the most successful operation for the correction of posterior deviations of the uterus. A study of the results obtained from the various methods now in vogue will, I think, fully explain the diversity of opinions.

In many cases the remote effects of the operation are *nil*, owing to the recurrence of the displacement, and in others the operative complications have interfered with the permanent success of the method employed.

As 17 per cent. of gynecologic patients come within the domain of posterior displacements, it is important, in considera-

tion of such a percentage, to arrive at the *best* means for their relief.

If the uterus is permanently restored to its normal position, and its functions as an organ not interfered with, there is no surgical procedure followed by more complete relief to the patient.

The indications for operative interference in posterior displacements of the uterus are considered from the patient's standpoint, as follows :

If the case is one having a simple, uncomplicated posterior displacement :

Has she sufficient symptoms and morbid conditions to warrant an operation ?

If such be the case, has she been given the benefit of careful replacement of the uterus, followed by systematic tampon treatment, with final adjustment of a properly-fitting pessary ?

If this has been conscientiously carried out, and failed to permanently relieve, as it does in 75 per cent. of women so treated, then we look upon the case as incompatible with a comfortable existence, and requiring surgical aid.

The cases complicated with adhesions, and more or less prolapsus of the adnexa, all warrant operative interference. The ordinary local tampon treatments, with the omnipresent vaginal douche, are of no benefit, and often harmful !

When there is a firm pelvic floor as a foundation, there should be an elective operation upon which the surgeon could depend for ultimate results, and as free from complications as operations performed in other parts of the body.

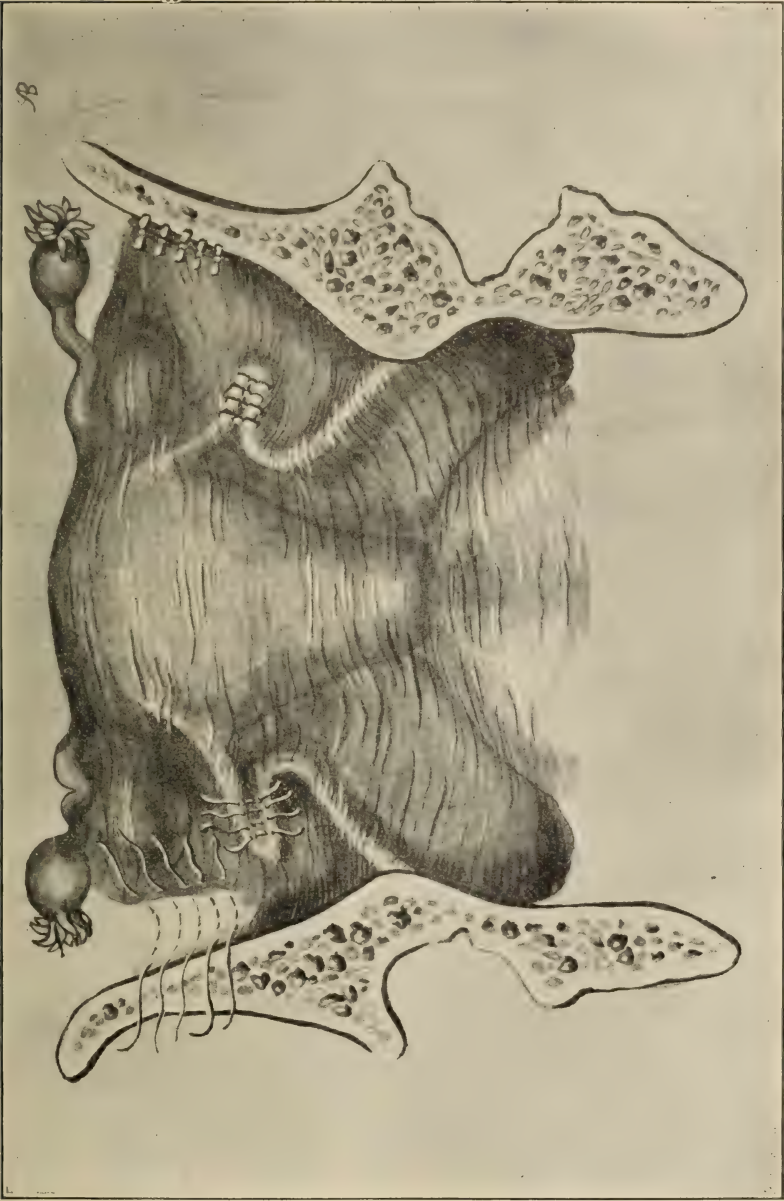
In considering the *modus operandi* for the relief of these women we must keep in mind the obstacles to be overcome, namely : The direction of intra-abdominal pressure upon the uterus, the normal action of the sustaining ligaments, and the weight of the uterus.

We have here combined influences for consideration.

When the uterus is in its normal position, it is suspended in the pelvic cavity by its ligaments, as follows :

The broad ligaments, extending to the sides of the pelvic walls, giving lateral support.

The round ligaments, sustaining the uterus to a great extent in its natural position of slight ante-version.



At the right side of the pelvis is shown denudation made and sutures *in situ*. At the left side the sutures are tied with the parts in apposition.

The utero-sacral ligaments are decided factors in their constant action toward keeping the lower uterine segment drawn backward, thereby aiding the position of the fundus forward.

The anterior vesical ligaments are worthy of mention, especially demonstrating their function as tensors when the bladder is distended.

From the location of all these ligaments we can infer that the uterus is not held up by them, but is sustained in its normal position by their combined action; and the organ remains in this physiologic position so long as the vagina, the lower segment of the rectum and the bladder remain free from morbid tissue changes, which induce traction upon the uterus.

The structures of the pelvic floor, then, are the foundation upon which the uterus depends for its main support.

The effect of intra-abdominal pressure against the posterior surface of the broad ligaments and uterus is one of the important forces which keep ante-version well sustained.

The range of motion which is normal to the uterus must not be lost sight of when operating for the relief of these posterior displacements. Movements of the fundus in any direction necessitate the cervix moving to an opposite point.

Aside from these movements, the uterus is raised and lowered rhythmically with the respiratory movements.

You observe this in many patients during a pelvic examination, when the abdominal muscles are in a state of relaxation.

Any interference of these normal movements by operative measures will fall short of the ultimate results we are seeking.

In a few instances complications may arise, coexistent with the displacement, which, even with extreme care, could not have been foreseen. (Rare.)

Practically speaking, almost all the operations performed for the relief of posterior displacements have a minimum of mortality, compared with abdominal cases generally.

Of the various methods and technic, I will only mention a few of the most successful, for their number is legion.

Vaginal fixation, fostered by the Germans, has the disadvantage of lacking a fixed point as an anchor.

The area where the sutures are introduced is quite movable with the uterus attached, so that a posterior deviation may be secondary to the operation, after all.

More than this, the complications arising from the pregnant state following this method have been such as to warrant most operators in discontinuing its performance.

Fergusson's method of indirect ventral fixation, by which the round ligaments are transplanted into the tissues of the anterior abdominal wall, has the advantage of a movable uterus, but the disadvantage of making traction out of the normal line; hence allowing the uterus abnormal range of backward movement.

Ventro-fixation is a very satisfactory method; but the consensus of opinion at the present time is that it should be limited to post-parturients.

The method of Mann and Wylie, of shortening the round ligaments through the abdomen, gives satisfactory results where the adnexa also require either enucleation or plastic repair.

For rectifying posterior displacements of the uterus *per se*, there is no better method than that of Alexander.

Where cases are not complicated by adhesions, adnexal disease, etc., this operation will produce a vast majority of cures.

The general run of cases have these very complications to contend with, which must be treated before the uterus can be successfully replaced.

Where adhesions bind the uterus firmly down to the adjacent structures, whether these be ovaries, tubes, intestines or omentum, the result remains the same; the organ is incapable of being raised to its normal, ante-verted position, and maintained there.

For cases of this class I suggest the following method, which combines the main features of the Sanger, Mann and Wylie operations:

The celiotomy incision is made through either recti muscle, near its inner border.

After walling off the intestines, adhesions around the uterus, tubes or ovaries are liberated by careful dissection, and the structures lifted up into the normal position, noting carefully at this time whether there is undue tension upon any of the parts; if such is the case, the areas of shortening are further liberated by dissection.

The distal end of one tube is now picked up near its fimbriæ and drawn over to the pelvic wall.

Preparatory removal of a small, narrow strip of peritoneum is made from the pelvic-wall side; then extending along the border of the infundibulo-pelvic ligament, and, where relaxation is marked, on to the tubo-ovarian ligament.

Sutures of number two catgut are now introduced from the pelvic side, across to the tubo-ovarian ligament; then on down the infundibulo ligament, placing them about five mm. apart, until the gap in the broad ligament is closed.

The same technic is repeated on the opposite side.

Next, the round ligaments are freshened along the borders, where reduplication will be made; and one or two folds (according to the shortening necessary to bring the fundus in its normal position) are brought together and sutured through, avoiding the small artery supplying the round ligament.

In examining the parts now, you find the uterus, ovaries and tubes suspended in their natural positions, with their normal range of movement uninterrupted, and the satisfaction of knowing that post-operative complications will not follow.

HOMŒOPATHIC TREATMENT OF GLANDULAR AFFECTIONS.

BY WALTER SANDS MILLS, M.D.,

Physician to the Metropolitan Hospital, New York City.

(Read before the Homœopathic Medical Society of the County of New York, October, 1902.)

I HAVE been asked to say a few words on the use of homœopathic remedies in glandular affections. I will begin by stating that glandular affections are no exception to the rule that any remedy may be called for in any condition. There are a few remedies, however, that seem to be called for more often than others.

Belladonna is one of the first remedies to think of in acute inflammations. The gland is swollen, red and sensitive to the touch. The patient has considerable fever, and presents the characteristic flushed face, brilliant eyes and full pulse of belladonna. This remedy is especially applicable to a swollen face, whether from a cold, from a bad tooth, or at the outset of mumps. My favorite potency is the third centesimal.

Phytolacca is another remedy that is very often indicated in acute glandular inflammations. If the symptoms do not distinctly call for belladonna, I am very apt to give phytolacca on general principles, for it is the greatest gland remedy at our disposal. I usually give it any way after a day or two, if belladonna has not benefited the patient. To illustrate :

On October 9, 1895, a schoolboy, 9 years of age, presented himself with the following symptoms: Hard, tense swelling in region of right parotid and sublingual glands. Impossible for the child to open his mouth, and difficult for him to swallow. Patient very nervous, sensitive to noises, irritable and tearful. Breath offensive. Temperature $102\frac{2}{5}^{\circ}$. He had taken belladonna for two or three days without getting much better. I gave him phytolacca, first dilution, in water, every hour. On the 10th the swelling was less; temperature $99\frac{1}{5}^{\circ}$; patient good-natured. On the 11th the swelling was gone and the temperature normal.

Phytolacca is good for inflamed lymphatic glands in any part of the body; it is good for buboes; it is almost a specific for mastitis.

Calcareæ Carbonica.—Chronic swellings of lymphatic glands, unless of syphilitic origin, are most frequently found in ill-nourished children. In such cases a constitutional remedy is needed. I have used *calcareæ carbonica* more often than any other remedy because it has seemed to be more often indicated. These patients present every evidence of malnutrition. They are anæmic, perspire excessively, have more or less gastric disturbance, do not sleep well, are fretful and irritable. The glands are hard to the touch, and respond very slowly to treatment.

Sulphur is the remedy recommended by Jahr to begin the treatment of glandular enlargements with. He follows this with *calcareæ carbonica*.

Calcareæ iodata has been highly recommended in tubercular adenitis. Some very favorable results have been reported.

Iodum is another remedy that has been used.

Mercurius solubilis has been given in glandular enlargements when they seemed about to suppurate, and has prevented their breaking down.

Hepar is of service after suppuration has become established, especially if the parts are extremely sensitive.

Silicea is of use in old glandular abscesses of long standing.

In goitre my experience has been limited. I will report one case.

June 28, 1894, a young woman, aged 19 years, native of Minnesota, presented herself for treatment. She had a distinct swelling of the thyroid gland. There was no pain, but the swelling caused slight interference with deglutition. Acting on the treatment as laid down by Jahr, I gave first *spongia*, third centesimal dilution. (The remedies are Jahr's, the potencies my own.) July 9th the patient reported a sore throat. The *spongia* was continued for several weeks.

Seeing no improvement, on August 2d I gave *sulphur* 30. Improvement, if any, was very slight.

September 26th *calcareo carbonica* 6x was given. The patient took this off and on for several months. Her general condition was much improved, but the swelling of the neck seemed to get gradually larger.

March 8, 1895, I gave *iodum* 3x. Improvement set in at once, and continued. May 29th the patient reported that she had been obliged to alter all of her dresses at the neck, the swelling having gone down so. She continued to take the *iodum* until August 1st, a period of about five months. At that time the neck was of normal size.

In July, 1899, the patient wrote me that the swelling had started again. The *iodum* promptly relieved it.

I have another case under treatment now,—a girl of 14, with an enlarged thyroid gland. I made my first prescription, *iodum* 3x, about five weeks ago. She thinks the swelling is going down.

In hypertrophy of the prostate I have sometimes been able to relieve the burning and scalding on micturition, and the desire to pass water frequently, with *mercurius corrosivus*.

Other remedies may be called for; it all depends on the symptoms presented by the patient.

In closing, I wish to say that I do not believe medication, homœopathic or otherwise, will relieve all patients suffering from any of the above conditions. Many of them can be so relieved; others will have to resort to palliatives or to the surgeon.

RECTAL EXAMINATION; ITS IMPORTANCE AND TECHNIQUE.

BY T. LOUIS ADAMS, M.D., PHILADELPHIA.

THE importance of careful rectal examination cannot be too forcibly impressed upon the minds of the profession. It would be impossible to estimate the number of patients to-day who, through the possession of a false modesty in themselves, together with the routine practice of the medical attendant of permitting the patients to make their own diagnoses, are supposedly suffering from "*piles*," when a careful and thorough examination would reveal the existence of much more serious trouble, which would, in the majority of cases, yield to proper surgical interference.

Fortunately the time has passed when the rectum, being considered the sewer of the body, was thought a part unfit for ocular and digital inspection. This much having been gained in the case of a patient applying for the relief of conditions thus situated who, after having the matter fully explained to him, still refuses to submit to examination, we have reached a point which forbids that the surgeon assume charge, lest he seriously jeopardize his reputation as a diagnostician, and possibly inflict an irreparable injury to his patient.

It is well, therefore, to start with a determination to take nothing for granted, the correct diagnosis and successful treatment being dependent upon the careful symptomatological and physical examination.

The patient should be requested to give, in his or her own way, a history of the condition from its inception; and until said history has been finished the patient should not be interrupted, as often such interruption will break the thread of the story, and important symptoms which have existed, or may at the time exist, be entirely overlooked.

From such a history it is often possible to make a correct diagnosis; but just here lies the danger, for it is a surprising fact that the patients of most intelligence will often completely mislead the examiner by their recital of existing conditions.

Having, however, gained this general information, we are in a position to make more direct inquiries.

1. As to pain: Its character; duration; its onset; whether before, during or after stool. Is it felt directly in the rectum, or in some adjacent part?

2. Protrusion: When does it occur—before, during or after defecation—or is it always present? Does it return spontaneously, or is it easily or with difficulty replaced?

3. The condition of the bowels: Is there constipation or diarrhœa; the calibre of the stools—whether normal, tape-like or lumpy; and whether tenesmus accompanies their discharge?

4. Discharges: Whether bloody, mucous, bloody mucous, muco-purulent, pus; time of occurrence—before, during or after stool, or entirely independent of the act; also odor of discharge.

5. Is there general systemic disturbance, fever, emaciation, cough, cachexia, exsanguination, or glandular involvement?

With this abundant information, it would be fair to assume that a correct diagnosis could be arrived at; but to demonstrate the fact that we have as yet far from positive evidence of the existing conditions, and that serious mistakes may be made if we hastily jump to conclusions, permit me to cite the history of but one of the many cases that have come under my personal observation.

A gentleman, thirty-one years of age, of good physique and absolutely negative family history, applied to me for the treatment of *piles*. He had been under the care of his regular medical attendant for some eighteen months, which dated the commencement of his trouble, and who, up to this time, had made no ocular or digital examination. The patient bled profusely at and after defecation, sometimes to the fainting-point; complained of weight, fullness, and slight protrusion after stool, which spontaneously returned; had no marked pain, and was exsanguinated. The blood was bright, and at times slightly mixed with clear mucus, with slightly offensive odor. There was no glandular involvement, and so far as he knew there had been no febrile condition, the systemic disturbance having been supposed to be due to the great loss of blood. Here was a case which, from its history, I supposed to be, and might readily have been diagnosed to be, arterial hæmorrhoids.

Carrying my examination further, an inspection of the anus and anal region showed an apparently healthy condition—no redness, swelling, or special tenderness. Upon the introduction

of the finger, however, a mass was discovered above the internal sphincter involving the entire posterior and lateral walls of the rectum, and extending beyond the reach of the finger, toward the sigmoid; it was friable, and bled upon the slightest touch.

I was then in possession of unmistakable evidence, and, with perfect confidence, diagnosed an epithelioma. This diagnosis was confirmed by Professor Van Lennep, who subsequently successfully operated him.

Let us then proceed to a consideration of the manner and technique of the physical examination, which alone will confirm the conclusions so far reached.

In this advanced age of antisepsis it will be unnecessary for me to dwell upon the importance of rigidly adhering to its every minute detail, which is just as necessary in rectal as in gynecological work.

The patient should be asked if there has been a bowel movement before presenting himself, and, if this has not occurred, an enema should be given and the rectum cleaned out, unless it is possible for him to have a normal movement at that time. The use of the enema, while at times necessary, is attended with disadvantages, for it may wash out discharges that would be diagnostic, and, in addition, so liquefy the fecal mass higher up in the sigmoid as to materially interfere in our specular examination.

Position is of great importance, and the one found to be most convenient is that of Marion Sims. The table, or couch, should be from six to eight inches higher than the ordinary operating-table, and the examiner seated on a stool of sufficient height to bring his head directly on a level with the buttocks. The patient being placed in position, with the examiner's hands on either buttock, gentle traction is made, when a perfect view is obtained of the anus and surrounding tissue. Pathological changes are now readily noticed. We now carefully palpate the ischio- and peri-rectal spaces and region of coccyx, noting whether there is redness, tenderness, induration, diagnostic of the presence of deep-seated abscess, internal fistula or malignant growths. Look also for discharges upon the skin surface, which may be due to the presence of a pin-hole opening of an external or complete fistula, or superficial abscess. Directing the patient to bear down, and at the same time making traction at the

margin of the anus, a perfect view will be obtained of the mucocutaneous junction, showing the presence of marginal piles, fissure, and superficial fistulous openings.

Next we come to the digital examination, and it is surprising how readily the educated finger will recognize almost all varieties of rectal disease. The examiner must, if successful, be thoroughly familiar with the normal rectum, and then systematically conduct his examination. The injection of from twenty to thirty drops of a 2 per cent. solution of cocaine will render the examination practically painless. The nails of the index and middle fingers (for it is at times necessary to employ both) should be carefully trimmed, and all roughness of same removed. They should then be covered with a lubricant (preferably Houghton's cosmoline, by reason of its body). The introduction of the finger should be accomplished by a gradual rotary motion, thus avoiding undue spasm of the sphincter, which may be induced if rapid and forcible measures are attempted. Now notice the condition of the muscle,—whether normal, unduly relaxed, or spasmodically closed and hypertrophied. Either of the last-named conditions is primarily the result of chronic irritation above, and subsequently becomes a pronounced factor in aggravating the conditions which produced them. The finger should now be introduced to its fullest extent, and a careful sweep of the entire rectal pouch made. Note particularly the condition of the mucous membrane; if smooth and the normal folds absent, it would denote atony, and the possible presence of obstruction above. The presence of pedunculated or other growths and ulcerations can be readily distinguished; indurations will be felt, and, when suppuration has taken place, fluctuation distinctly observed. Internal openings of fistula, which at times are of sufficient size to admit the end of the finger, can be distinguished without difficulty. Narrowing of the gut is also easily distinguished, and may be the result of trauma, ulceration, malignancy or specific infection. *Do not expect to be able to detect internal hæmorrhoids by digital examination per se*; they are so perfectly compressible as to disappear beneath the examining finger, and only after long-continued inflammation, resulting in their structural change, is it possible to determine their presence.

Having completed our digital examination, ocular inspection

by means of the speculum is frequently necessary to make our assurance doubly sure. Great difficulty has been experienced by rectologists in obtaining a satisfactory instrument of this kind, and, in consequence, the varieties are innumerable. For myself, I have found most satisfaction in the tubular or cylindrical speculum, fashioned after the Ferguson vaginal, fitted with an obturator to facilitate introduction, and a handle set at an angle, giving perfect control of the instrument. They can be made in various diameters and lengths, to suit all conditions which are liable to be met. Their great advantage lies in the fact that a complete exposure of the rectal mucosa can be made with the one introduction, for the reason that they can be rotated, prolapsing point after point into the end without causing discomfort to the patient. This is not so with any of the bi-valve speculæ, for upon the opening of the blades the mucous membrane or growths will immediately prolapse within them, thus obstructing the view, and making rotation impossible and several reintroductions necessary. In the use of the tubular speculum it should be introduced to its fullest extent, the obturator withdrawn, and the examination made from above downwards. Grasping the handle firmly, and with a gentle, complete rotary motion, not a single point in the rectal mucosa will escape the examiner. As an adjuvant to their use, light is most essential, *and no light is so satisfactory as North daylight*, it being absolutely void of shadow. It is possible, with such a speculum and light, to perfectly explore the entire rectal pouch.

For examination of conditions involving the sigmoid and lower colon I beg to call attention to what I consider a most useful instrument—that of Dr. Teller, of New York, and manufactured by the Electro Surgical Company of Rochester, N. Y. It consists of the aforementioned tubular speculum, fitted with an electric lamp at its distal end. After its introduction, and the withdrawal of the obturator, a glass window is fitted snugly into its outer end. To this window is attached a rubber tube, supplied with a compression bulb, as used in the Paquelin cautery. The light behind being turned on, air is gently pumped into the bowel, and as inflation takes place the mucous folds separate, the sigmoid straighten out, and often it is possible to expose a considerable portion of the descending colon. At all times the instrument is under control, and the danger is obvi-

ated that would be incurred in the use of the long tubular sigmoidoscope, as recommended by Dr. Kelly.

Bougies used for diagnostic purposes, or in the treatment of strictures, especially those situated high up, unless in the hands of the most experienced, are particularly dangerous. Extensive ulceration, resulting in stricture, renders the rectal wall in their immediate vicinity particularly friable and liable to rupture; and, of course, should such an accident happen, we could rest assured that direful results would obtain.

In conclusion, let me make a plea for the more careful consideration of the diseases affecting the rectum and its immediate region. An early diagnosis, followed by the properly employed treatment, will be a boon to the many who silently suffer by reason of their complaints being considered too lightly by those to whom they apply for relief; and if this short *résumé* has been sufficiently clear and interesting to awaken some interest on the subject, it has fulfilled most abundantly the desire of the writer.

GASTRIC ULCER COMPLICATING TYPHOID FEVER—A CASE.

BY WILLIAM F. BAKER, A.M., M.D., PHILADELPHIA.

THE presence of gastric ulcer as a complication of typhoid fever has been verified by good observers, the occurrence of the clinical symptoms in the course of the fever calling attention to the probable existence of the lesion, and in a few cases post-mortem examination revealing ulceration and necrosis of the walls of the stomach. It has not, however, been proven that gastric ulceration is dependent upon the typhoid bacillus alone, though competent observers have investigated the matter. That its presence has not been proven may find explanation in (a) the scarcity of diagnosed cases; (b) the inaccessibility of the lesion; and (c) the lack of opportunities for post-mortem examination. We all admit that bacteriology has advanced, and on no subject has it been more successful in clearing up misunderstanding than on the many and varied sequelæ and complications of typhoid fever; but in regard to this one feature its results are inconclusive. Are we justified in assuming that

these ulcerations will ultimately be proven to be caused by the same organism that induces ulcerations in the other accessible mucous membranes, viz., those of larynx, vagina, or intestines? Eppinger and Landrof hold that the epithelial necroses are the result of streptococcic and staphylococcic invasion. Other observers look upon them as being due to disturbance of the circulation and the innervation of the tissues.

The symptoms which, in the recorded cases, have called attention to this complication have been nausea, vomiting, epigastric pain, and hæmatemesis. The symptoms in the case about to be cited included all of these, and, in addition, distressing eructations of gas. Vomiting is not uncommon in the course of typhoid fever, but, as a rule, it disappears at the end of the first week. Anders, however, in mentioning the occasional occurrence of vomiting as a symptom in typhoid fever, cites a case in which it developed immediately after the first hæmorrhage from the bowels, and was persistent. He says, "The fact that the vomiting occurred at the time of the various copious hæmorrhages would go to show that the ulcer from which the blood came was high up, and possibly in the stomach." Allbutt admits vomiting and epigastric pain as evidence of inflammatory changes and ulceration of the stomach. Possibly no one writer has been more positive than Pepper, when he says "both perforation and gastrorrhagia have been caused by typhoid ulceration."

The possible occurrence of such a complication having been verified by good observers, it may be well to summarize the symptoms on which one may base a diagnosis. We are, perhaps, apt to overlook this complication through our inability to discover "typical cases." In the present instance, however, there is no lack of diagnostic data. The symptoms of a typical case of gastric ulcer, independent of its etiology, would be nausea; vomiting; severe and persistent epigastric pain; hæmatemesis; and a tender epigastrium, with a point of exquisite tenderness situated just below the ensiform cartilage. Pressure on this spot may bring out the somewhat characteristic "knife-stab" pain. All of these symptoms were present in my case.

CASE I.—A boy, 16 years of age; had been going to school, but was forced to give up on account of a marked anæmia.

Family History.—There was a history of "stomach troubles"

on both his father's and his mother's side. The father is, at the time of writing, suffering from symptoms of gastric cancer, and progressing weakness has compelled him to give up work.

Personal History.—The child was always delicate, and did not seem to thrive until he had passed the age of five years. Has had the usual children's diseases. Has been suffering from anæmia for the last five months.

Present Illness.—One week ago he began to complain of feeling tired and very weak, with anorexia, and a severe frontal headache, throbbing in character. The temperature taken at this time showed a fever of 101° F. Notwithstanding absolute rest in bed and a milk diet, the child grew weaker and more apathetic day by day. The temperature rose by evening exacerbations until in the course of ten days it had reached 103.5° F. Not long after he was confined to bed a profuse diarrhœa, greenish and foul-smelling, presented itself. About this time, also, a troublesome nose-bleed came on, and seemed for a time almost uncontrollable. The child grew restless, more apathetic, and a nightly delirium of mild type showed itself. The tongue was heavily coated, with a white centre and red edges and tip. The temperature at the middle of the second week was running from 102.5° F., morning, to 103.5° F., each evening. The abdomen was distended, tender to pressure, and covered with a diffuse rash, which disappeared on pressure. The spleen was considerably enlarged. The urine showed a specific gravity of 1025, and was scanty and high-colored, with a trace of albumin and deficient urea. The heart had held its own up to this time, the pulse being 110, fairly full and strong. Blood examination revealed a positive Widal reaction. From the above outline it may be seen that the case was unquestionably one of typhoid fever approaching the end of the second week.

At this time my attention was called to the fact that the child complained of pain, and raised large quantities of gas after each feeding. This was soon followed by vomiting of the food. This condition was at first attributed to faulty dietetics. On examination of the vomited matter, however, I found that it consisted of curdled milk, bile, and small, dark clots of blood. Further examination revealed the presence of yet greater

quantities of blood. Two days later the patient complained that pain was becoming very severe, and felt as though some one was stabbing him, or, as he put it, "as though the point of a knife was sticking through the back." I concluded, therefore, that it was advisable to place him on rectal feeding.

Examination of the epigastrium at this time disclosed the fact that it was very tender, and a spot of exquisite tenderness was found just below the ensiform cartilage. Pressure on this spot caused the little patient to cry out. The bowel movements at this time were examined, and found to contain a considerable number of dark clots.

With the rest to the stomach afforded by the rectal feeding the pain gradually lessened, and after six days vomiting ceased, but it was followed by severe retchings and nausea, showing the irritable condition still present in the stomach. This, of course, added greatly to the distress of the patient, the retching greatly increasing the pain. After ten days of rectal feeding he was given first cracked ice with unfermented grape juice, peptonized foods, and milk. The sharp appetite usually found in patients convalescent from typhoid was lacking, however. Following the subsidence of the pain and return to feeding per mouth, the symptoms gradually disappeared and recovery began, but convalescence was very slow. The temperature remained slightly elevated for four weeks, then gradually returned to normal. Solid food was thereafter taken without distress, and there has been no return of the symptoms since recovery, a period of nearly one year.

From the above case the following conclusions may be drawn:

1. Ulceration of the stomach is a possible complication of typhoid fever.

3. The exact causation of the lesion is unknown, but in all probability investigation will prove such ulcerations to be due to the typhoid bacillus.

3. Guiding symptoms are (a) vomiting; (b) epigastric pain; (c) hæmatemesis.

4. The physical examination, *i.e.*, the finding of a spot of exquisite tenderness in a tender epigastrium, affords confirmation of the diagnosis based on the symptoms.

5. Rectal feeding may be used to considerable advantage in the treatment of typhoid fever thus complicated.

6. In such cases convalescence is necessarily protracted by reason of the care one has to exercise in feeding.

NOTE.—This case was one occurring in the out-patient service of the Hahnemann Hospital. The notes are those taken from a clinical lecture, and are given as there recorded.

A CLINICAL STUDY OF LUMBAGO.

BY M. E. USILTON, M.D., PHILADELPHIA.

LUMBAGO should, in my opinion, engage far more attention and investigation than is at present given to it by the medical profession. We may pick up any standard text-book on medicine and find only three or four lines devoted to this, I might say, common affection; whereas pages are given to other much more uncommon and considerably less important conditions.

The first question which arises in the study of this condition is, "What is lumbago?" and the medical profession, in common with the laity, answers, "Pain of a rheumatic nature in the lumbar region,"—and there our present knowledge practically terminates. We all know that lumbago is generally considered one of the forms of myalgia in which the muscles of the lumbar region, one or all of them, viz.: quadratus lumborum, erector spinæ, and part of the latissimus dorsi, are affected. We call it lumbago in the same manner as that in which we speak of torticollis, a myalgia of the antero-lateral muscles of the neck; pleurodynia, a myalgia of the intercostal muscles, etc.

But what is myalgia? We answer, "Pain in the muscles," or, some say, "muscular rheumatism." That tells us about as much as when we say gastralgia is pain in the stomach. It is *merely a symptom, and nothing more.* We know practically nothing as to the nature, morbid anatomy or pathology of either condition. We say gastralgia is a sensory neurosis, but more often it is only one symptom of a general condition.

Lumbago is thought by some to be one of the manifestations of the gouty diathesis. Its infectious nature has been suggested, as well as the possibility of it being a form of lumbar neural-

gia, or neuritis of the sensory nerves. Some go so far as to say that lumbago is only a symptom of a developing kidney lesion, and that sooner or later we will find evidences of this in the urine. I am not in a position, as yet, to discuss these theories, but will give some facts and comparisons as found in a study of 50 cases of the conditions diagnosed as lumbago in our medical department of the dispensary.

First, as to the frequency of its occurrence, I found that it occurred in about 4 per cent. of all cases coming to our department for treatment. As to the season of the year in which it was most common, it was found that during the wintry months of December, January, February and March there was a total of 32 cases, and during October and November 10 cases, leaving only 8 cases to occur during the remaining six months, and these were about evenly scattered through that period. As to sex, it is interesting to note that of the 50 cases diagnosed as lumbago, only 11 were of the female sex. This can partly be explained by the fact that most of the women complaining of "pain in the back" are sent to the gynæcological department, and are presumably treated there for some uterine or ovarian trouble. I do not wish to underestimate the number of cases of uterine and ovarian diseases which have this prominent symptom of severe pain in the back as the main one, as we all know the number of cases of this kind occurring in women; but it is probable that in some cases an actual lumbago co-exists. As to etiology, 20 cases were said to be traceable to a traumatic cause, such as a strain, or the falling of a heavy weight upon the lumbar region; 12 cases were due to exposure to damp weather or drenching rain; 3 cases to sudden chilling of the body after working about a hot furnace (these 3 cases occurred in men employed at Baldwin's Locomotive Works); and in the remaining 15 cases no cause was given.

In regard to age, 15 cases were in persons ranging between the ages of 40 and 55 years, which latter age was the highest noted; 30 cases occurred between the ages of 30 and 40 years; and only 4 between the ages of 25 and 30. One case was in a young man of 22 who was seized with a sudden pain in the lumbar region after attempting to lift a heavy trunk, and this case was very obstinate in its course.

As to occupation, 31 patients were of the laboring class, 9

women were housewives, and there were 3 motormen, 1 conductor, 2 clerks, 2 students, and 2 printers.

These statistics show that lumbago is most common in the laboring men somewhat below middle age, and during the season of the year when we have our worst weather. These laborers are naturally more exposed to storms, the strain of heavy lifting, and traumatisms.

In going over the personal history of these cases I was struck with the number who had suffered from previous attacks, showing that one attack predisposes to another; 38 cases out of the 50 had had previous attacks. There were 15 cases who gave a history of having had rheumatism or rheumatic pains; but when we consider the number of cases so diagnosed which were not rheumatic at all, but whose pain was a manifestation of some other disease, such as syphilis or malaria, or was the pain of a developing kidney lesion, neuritis, chronic bladder or deep urethral pain, and also the fact that only 11 out of the 50 had any aggravation from wet weather, we are forced to the conclusion that, contrary to the statement in the text-books, true rheumatism, "rheumatic fever" does not have such an important relation to lumbago as is generally supposed. As regards gout, only 3 cases gave a history of having had anything resembling this trouble, and but 6 gave any family history suggestive of gout. Of 40 urinary reports in these cases, 11 contained uric acid, and only in 4 of these was it very abundant. When we consider that the cases coming to us do so at the height of the trouble, when there should be the greatest amount of uric acid in the urine, if the uric acid diathesis is the foundation of lumbago, we must conclude that gout bears no consistent relationship to the condition. Only 8 cases out of the 50 had any urinary symptoms at all, and these were mostly in men over 45, and were probably due to enlarged prostate. It is hardly necessary to state that there were no signs of albumin or casts in any of the cases.

From the above statistics, together with the symptoms noted below, I am inclined to the belief that lumbago is due to a simple hyperæmia of the muscular stria, sometimes going on to an actual inflammatory condition of the muscles, as the result of exposure and chilling of the surface. In chronic cases a proliferation of connective tissue may take place.

The symptoms of this affection, as noted in the records, are as follows: Pain in the lumbar region, varying from a sharp, cramp-like form to a dull, aching pain, usually confined strictly to the lumbar region and loins, and worse on any movement. Tenderness, or rather a sense of soreness to touch in the lumbar region, was noted in all the cases. Some slight swelling or bulging was seen in the majority of the cases examined carefully. I regret to state that in my own records, as well as in those taken by others, no mention is made of any redness or unusual heat of the surface in the lumbar region. I shall be more careful in the future to note this. Constipation was present in 25 out of 45 cases, the state of the bowels not being given in the remaining 5 cases. No rise of temperature was noted in any case. The first and the most important condition from which, it is supposed, we must differentiate lumbago, is kidney disease. That can easily be done by systematic and careful physical, chemical and microscopical examination of a 24 hours' specimen of the urine, made not only once, but repeatedly. Too often we are contented with a single examination of the patient's urine, and, having found it negative, we proceed to diagnose the case as one of lumbago. A neuritis of the sensory nerves of the lumbar muscles, which some authorities give as the basis of lumbago, can be distinguished by the presence of tender points. In lumbago there is, instead, a general soreness to touch; moreover, the pain in neuritis is darting and stabbing in character, while in lumbago it is a dull ache, or it may be cramp-like in character. In neuritis it follows the course of the nerves, and is not so strictly confined to the lumbar region as in lumbago. We must also exclude sciatica, hip-joint and sacro-iliac disease, and also renal colic. In the latter affection the pain begins in the lumbar region and follows the ureter. Appendicitis and gall-stone colic often have pain referred to the lumbar region, and sometimes may be mistaken at the beginning for lumbago. As above indicated, we must always exclude uterine and ovarian disease. The affection we call coccygodynia may also be mistaken for lumbago; but here the pain is lower down, is aggravated by sitting posture and on any bent movement.

In the treatment of lumbago rest is of the utmost importance; but in the patients who are treated in a dispensary we

can never rely upon this, and must depend upon internal remedies and local measures. Massage and dry heat, as with the flat-iron, has been found to be more useful in the majority of cases than hot fomentations or thermal baths. Besides these measures, the constant current is often beneficial, and some authorities recommend acupuncture of the lumbar muscles with needles 3-4 in. long, in acute cases. Persons afflicted with this disease should go warmly clad and avoid all exposure, as well as straining of the muscles. The importance of relieving the constipation in these cases of lumbago cannot be overestimated, as a number of cases were completely relieved of the pain after one or two free bowel movements. Of internal remedies, *rhus toxicodendron* was prescribed in 32 out of 50 cases, and with good results, without regard to the symptom of relief by continued motion. *Bryonia* was given in 10 cases, and *gelsemium*, *actæa racemosa* and *nux vomica* were occasionally prescribed on symptomatic grounds. *Arnica* gave a good result in the traumatic cases.

ANTHRAX CURED BY THE INTRAVENOUS INJECTION OF ARGENTUM COLLOIDAL CREDÉ.—Schrage (Finimel, Germany) records the case of a man, æt. 75, who infected himself while assisting at the post-mortem of a horse that had died of anthrax. Both arms were infected, and the patient, when first seen, presented extensive malignant pustules on the anterior surface of both forearms, his pulse was rapid and irregular, and his temperature was 104.5° F. in the axilla. His blood showed the characteristic bacilli. Dr. Schrage's attention had been attracted by Fischer's account (*Munch. Med. Woch.*, No. 47, 1901) of a case of anthrax of moderate severity cured by injections of Credé's colloidal silver, and he determined to try it in this apparently hopeless case; and 3 c.c. ($\frac{3}{4}$ drachm) of a 1 per cent. solution of collargolum was injected into the left cephalic vein, while camphor emulsion was administered because of threatening heart failure. Next day the condition was still bad, the local condition unchanged, temperature 101.3° F., pulse rapid and irregular. Injection was repeated. Next day the patient was much better, the pulse full and regular, and the temperature 97.9° F., and the swelling commenced to go down. No further injections were given, but 10 grammes ($2\frac{1}{2}$ drachms) of unguentum Credé were injected in the course of three days. The patient remained afebrile, his strength increased, and in the course of a few weeks the necrotic tissue was entirely cast off.—*Allg. Med. Central-Zeitung*, Aug. 9, 1902.

EDITORIAL.

FIAT JUSTITIA.

IN this age of expansion, when we see every branch of industrial enterprise extending its borders by consolidating or merging into itself kindred activities, we need feel no surprise at finding the same spirit of the times seeking to control the medical profession. A couple of months ago we were called upon to speak of a suggested merging of the various allopathic and homœopathic colleges into a huge conglomeration of institutions in the Vienna of America. The idea of merging the two dominant schools of medical practice into one is ever being presented to us with a most alluring picture of the peace and harmony which would prevail were that vast medical trust to be consummated. We are, therefore, in a measure prepared to comprehend this merging process as one consisting of a grouping of several independent but allied forms of activity under one wider, more comprehensive form, on the basis of community of interest. Hence it has never seemed unnatural that the clinical reports of different authors of various lands should be grouped together and given to the profession as *International Clinics*; but we were not prepared, we confess, to find grouped with these a section on *Biographical Sketches of Eminent Living Physicians*, as is done in Vol. II. of the Twelfth Series of the *International Clinics*. We are at a loss to understand just how these are to be viewed in their relation to clinics. We can understand why a steel company should wish to absorb iron mines, or a railway company both mines and a steel company; but why the reports of clinics should be made to include the lives of clinicians we cannot comprehend. If the case were turned around, and biographical sketches were made to include reports of the work of the ones biographized, it would be logical and intelligible; but as it is, it does not appeal to our sense of the eternal fitness of things. Our tender sensibilities are still further wounded when we find that the

Biographical Sketches of Eminent Living Physicians reduce themselves to a single one, and that in no sense a biographical sketch. We find a good picture of a distinguished man, but look in vain for anything in the way of a biography. Instead, we have an extended list of his office hours and hours on duty at various hospitals, the time he takes his luncheon and dinner, together with an instructive mention of his manner of collecting fees. Now, this may all be very interesting, but can hardly be regarded as strictly belonging in a work devoted to the reporting of clinics. It savors too much of the well-known "unsolicited testimony" as to the efficacy of some new drug; it smacks too much of flagrant commercialism.

But stay,—the author may have had another object in view. It may, in reality, be a clinical report wrapped in true Baconian cipher. It may be the report of a case of *Fames auri sacra*, known and named as early as Virgil's time, and much earlier. We find it but imperfectly and obscurely reported, but yet we can distinguish prodromes, periodicity in the paroxysms and periods of remission.

As prodromes we recognize the reception of the fee by the office attendant in the waiting-room, before admission to the doctor's private office: the doctor receives no money in the office himself. A kind of pseudo-anorexia marks this initial stage. It may even amount to actual anorexia, when "some hypercritical individual objects, and the attendant very politely excuses him from the office and gives his number to the next."

The paroxysms occur every day, except on Tuesday and Sunday, and last from 8 o'clock in the morning until noon at the hospitals, and from 2 to 6.30 in the afternoon in his office. From 12 to 1, the time devoted to luncheon, and again from 6.30, devoted to dinner, he coughs up q. s.

From 8 P.M. until 11 there is a remission of the symptoms, and a period marked by correspondence, reading and writing, followed, no doubt, by a sound sleep in some kind of hygienic buttonful pajamas.

Only in some such imperfect way can we find for this unbiographical biography a *raison d'être*. Standing as it does, uninterpreted, it strikes us as entirely irrelevant, but as a very clever bit of advertising,—one against which but few of even the most ardent upholders of the Code will venture to raise

their voices. The fresh graduate, unknown to fame and unheralded by friends, is compelled to settle down obscurely, announcing his presence by a modest sign on door or window-sill, and is forbidden by the Code to put on his card a mention of his specialty, or in the newspapers his name and residence. Who is allowed to know or to care whether and where he works or eats, or how he extracts the unwilling fee?

We believe that somewhat more latitude is allowed in the matter of advertising in the West than here in the effete East; but nowhere, so far as we know, is the attitude of the general profession in this regard a just one. To him who hath shall be given. The physician or surgeon who needs no advertising gets it, while the one who needs it most gets none of it. Happy he who knows a reporter, and sees, or does, or suffers something which can be reported. Thrice happy he who can give, in strict confidence, to the friendly representative of some newspaper his views on a current topic, be it perityphlitis, filtration-beds, coal strikes, typhoid fever or corsets. There are various ways of whipping the devil round the stump, and some there be who know them, while others do not. Until the knowledge of them becomes universal, more leniency should be shown in this matter.

While at the present time and in the present state of professional thought we do not advocate a pulling-down of all barriers, and a relegation of the Code to the "demnition bow-wows,"—where, for many reasons, it properly belongs,—we do think that justice demands either greater liberty to all or greater restrictions for all. With the commercialism which is daily attaching itself more closely to the practice of medicine, we feel assured that the time is not far distant when with it will come a recognition of the principle that all physicians should be allowed to conduct the business end of their lives according to approved modern business methods. Thus only can justice be meted out to all, and discrimination against the weaker and more obscure members of the profession be avoided.

THE GOLD MINE IN FRONT OF THE DOOR.

“THE great trouble is,” said one of our friends one evening, “that very few people recognize that their gold mines lie in front of their doors. When I came into my inheritance, about \$100,000, I was anxious to do big things with it. So I went into business. Various causes co-operated to make it a financial failure, and I got out with nothing but my good name left. Had I invested that money in — Street railway stock, which was then paying six per cent. on par value, my investment would have been worth \$600,000 by this time. My gold mine lay in front of my door; it passed by it; but I did not have sense enough to know it.”

Almost every mail brings to our desk a communication inviting us to invest our hard-earned money in various ventures, promising a remuneration of anywhere from 20 to 1000 per cent. per annum. These circulars are skillfully worded to deceive the unwary and inexperienced. To those who have been “caught” they are so transparent that they wonder how any one could be so credulous as to be caught by such schemes. The companies being promoted are nearly always doing business at a distance,—anywhere, in fact, from “Greenland’s icy mountains to India’s coral strand,” or from Alaska to Patagonia. As a rule, too, one finds among the list of those interested in the scheme the name of some prominent man, oftentimes of a physician. Why a physician should be regarded as a good authority of the value of an investment we do not know. To our mind, his testimony is about as valuable as that of a clergyman to a patent-medicine advertisement—and that is not saying much, we are sure!

The appended list of supporters does not amount to much if one but knew the manner in which the support is commonly gained. For example, one of our intimate professional friends received a letter from a physician somewhere, stating that he was interested in the promoting of a company of some kind. The board of directors wished the co-operation of our friend and the use of his name as a large stockholder. Knowing the value

of his support, they had voted him 1000 shares of stock in the company. A circular was enclosed, including, among the stockholders, the name of our friend. Think of that, ye lambs! Needless to say, the stock was returned, with indignation at the outrage. An apology came in due time, stating that a large number of circulars had been mailed, but the remainder would be destroyed.

A solicitor called on us to secure our interest in a company. Dr. X. Z. Y. was mentioned as having looked over the properties of the company, and was enthusiastic as to the prospects. We knew X. Z. Y., and asked about the report. We were told that he had seen the property, but did not think enough of it to put his money in it.

This shows how much one can believe.

Doctors are looked upon as gullible. The average promoter knows this only too well. We have been told of one case where a man of high standing was used as a cat's-paw so successfully that he was indicted by a grand jury, while the monkeys back of him escaped, so skillfully was their work planned.

As physicians we recognize and have as our motto: "Every man we meet knows something we do not; we must find it out and appropriate it." The promoter paraphrases it: "Every man I meet has money which I have not, and which I want; I must get it—honestly, if I can; but I must get it."

Some doctors do make good investments; yes, we know that. But in all the cases with which we are acquainted they have put their money in "the gold mine in front of the door." One man buys real estate in his own town; another helps along in a local car line; another in a light company; but in all cases matters are so arranged that they can see how things are going, and there is an opportunity to close the business before the wreck comes, which it rarely does. There is no opportunity for watering of stock; no bonuses to prominent men; in each and every case there is a plain business proposition which is bound to succeed because of its firm foundation.

But aside from investments, physicians should remember that the gold mine lies in front of the door in another sense. With few exceptions the average physician is versed in but one thing, namely, medicine. If he pays attention to his profession he is almost certain to succeed. He has a hard time to

get a start, it is true; but year after year his practice increases, with the certainty of a fixed income. "His gold mine lies in front of his door." He should take good care of it. He must not get interested in anything but his profession, otherwise his profession will go back on him. We know physicians who have disregarded this and come to grief. Dr. — sold his practice, a very large one, put all his savings in a venture at a distance, and took part in the management of the company. Business methods were new to him. But now he has experience, and he has returned to the practice of medicine. As a man who has passed middle age, he finds getting a practice much more difficult than he did at first.

We hear people say, "We wish Dr. — was not interested in making gold out of sea-water. He was a good doctor until that fad came along. Now he can do nothing but talk of his fad in the sick-room. He takes no interest in our ailments. We shall drop him."

"Let the shoemaker stick to his last," is an old and wise saying. We would paraphrase it, "Let the doctor stick to his medicine." Let him, when he has money to invest, put it in something that is certainly good. Let him beware of investments promising large returns. Let him beware of concerns which make a specialty of bringing riches to physicians. It is a common saying that a man who borrows money of a woman has no credit among men. We would say that in the majority of cases in which companies seek investors among physicians, they cannot get the co-operation of the business world. We once said this to a promoter. He replied, "Yes, that is so; but our company is different." Nevertheless, that company became bankrupt, and one of our medical friends lost just \$8000, and numerous others sums ranging from \$100 to \$500.

We trust that the above words will open the eyes of the unwary.

AN ECHO FROM THE STATE SOCIETY MEETING.—It was very gratifying to the Retrospect man to see so many staunch homœopaths at our recent State meeting. It was still more gratifying to hear them give testimony to the truth of our therapeutic law. There are a great many homœopaths left in our profession, but the trouble with them is that they "won't speak up."

GLEANINGS.

SOME REMARKS ON INFLAMMATION OF THE VERMIFORM APPENDIX.—Prof. Frederick Treves, in the Cavendish Lectures recently delivered in London, traced back nearly all the most important symptoms in appendicitis to involvement of the peritoneum. This organ, the appendix, may be very seriously affected without any symptoms. Its walls may be thickened, its mucous membrane ulcerated, or the outlet narrowed, and yet no symptoms be noted. This has been proved by operations for other diseased conditions, or acute appendicitis, where the lesions found appeared to be older than the case, from its history, would warrant.

In other cases these lesions are accompanied by continual tenderness and pressive pains in the right iliac fossa, frequent and short attacks of stitching pains, or persistent disturbances of digestion, constipation, etc., yet without there being enough to diagnosticate chronic appendicitis.

In this classification of the different forms of the disease, he asserts that the appendix is liable to the same diseases as the rest of the intestinal tract. As special causes, he cites life in the tropics, with its frequent and various intestinal infections, distention of the cæcum, with all the conditions that accompany constipation, colitis, disturbances of digestion, faulty teeth, bolting the food, sedentary life, etc. Grape-seed and the like practically never cause appendicitis. Inflammation of the uterine appendages on the right side may lead to infection of the appendix, either directly or through the lymph-channels, subperineally.

He contests the value of McBurney's point diagnostically. It corresponds to the centre of the iliac fossa, and any organ involved there would be tender on pressure. Even normally there is a certain amount of tenderness there. The frequently-advised direct palpation of the appendix he cannot speak well of, for often that which is thought to be a horizontally or vertically dislocated appendix is frequently only a bundle of muscular fibres of the rectus, obliquus or transversus muscles.

In speaking of treatment, he mentions the difficulty of prognosis in cases treated either by operation or medically. He is very reserved in the surgical treatment of the acute attack. He asserts that the great majority of cases of appendicitis recover spontaneously, for the treated medically mortality is scarcely over 5 per cent., while out of those operated on during an attack, about 20 per cent. die. Such conditions as gangrene and perforation or appendicitis with acute peritonitis, should not be compared with similar states in other parts of the intestines. The former may heal spontaneously, and hence call for no imperative operative interference. Besides all these objections, an operation during an acute attack cannot wholly guarantee against a recurrence. Treves, therefore, takes an altogether different stand from those surgeons who would operate as soon as a diagnosis of appendicitis is made.

An immediate operation is only called for in the most acute cases where the symptoms develop with an intensity and a rapidity such as those which follow a perforation of the stomach or intestines. On the contrary, one should operate as soon as an abscess is detected. In all other conditions during the first few days one should be very reserved, and a decision as to whether one should operate may be put off until the fifth day, or later. The interests of the patient are best subserved if one allow the attack to terminate spontaneously, and then, when the disease has quieted down, one may extirpate the appendix *à froid*, and cure the condition definitely. Treves has done about one thousand such operations after the subsidence of the attack, and with only two deaths. He regards the operation as without danger, and advises it to be done in every one who has passed through a definitely diagnosed attack of appendicitis. He would except only one condition, and that where grave dietetic errors have led to a single attack, for then, with proper and sensible attention to one's diet, the future danger is little. Again, in those chronic cases with continuous pain and light acerbations without typical seizures, he would remove the appendix. —*Hospitaltidende*, No. 34, 1902.

Frank H. Pritchard, M.D.

ON THE ACTION OF ATROPINE IN OBSTRUCTION OF THE BOWELS.—Dr. Paul Ostermaier, of Munich, who has had some experience with atropine in incarcerated scrotal and inguinal hernias, as well as intestinal obstruction, reports a number of cases of incarcerated hernia where he has been able to reduce the hernia quite easily after having injected from one to two mgms. into the neighborhood of the sac. Often, after waiting for some time, the mass would disappear spontaneously. In one case he tried as an experiment to reduce the hernia without atropine, and only after half an hour of hard work did he succeed, but the difference was so great that he does not desire to repeat the experience.

For example, a woman of 75 years, whose hernia had been out for three hours, sent for him. The right-sided femoral hernia was so tender that even careful attempt at reposition caused her to cry out. After one mgm. of atropine into the arm it returned spontaneously within two minutes.

In a man of 50 years he found a left-sided inguinal hernia of the size of a dove's egg, which had been down for ten hours, and which was very painful and tense. On two different times the patient had been able to reduce it himself. His general condition was good, and his pulse normal. One mgm. was injected into the arm; fifteen minutes later another mgm. was administered; two hours later two mgms. were given in the same manner, this time in the region of the hernia. In three to five minutes after the last injection the hernia returned of itself. During the next few days the patient complained of great dryness of the throat; otherwise no toxic disturbances. The writer has made a study of the literature, and concludes that atropine excites peristalsis, and reduces the size of the mesenteric vessels by contraction. This action usually appears in one or two minutes after injection. Another feature is the improvement in the patient's condition, which is almost immediate. A certain dose of atropine must circulate in the patient's blood before this action may be observed, and hence he would advise beginning with not too small a dose at first—one or two mgms., repeated ever half hour, adding each time one and a half mgms. until the action on the intestine is manifest. The increased peristalsis is never too great, but seems normal; and if the peristalsis be spasmodic or

"stormy," the drug will quiet this. The contraction of the mesenteric vessels of course favors reduction of a hernia by decreasing the size of the incarcerated mass. He would even inject in the course of four or five hours ten mgms. of atropine if necessary, and then, if it fail, one may operate, if no definite result has been obtained within six to eight hours after the first injection. A great mistake in the use of this drug is in employing it in too small doses, and too late in the course of the case. It has been objected that patients do better under opiates, but many had enough of such drugs before atropine, as if by magic, changed everything for the best.

He further cites Dr. Bloss, who asserts that in the city hospital of Karlsruhe atropine has come to be the sovereign remedy after operation for appendicitis. It combines the sedative action of morphine with a specially favorable influence on the intestinal peristalsis. In peritonitis from perforation it was used from the first or second day after the peritonitis has disappeared and the atony had increased to paralytic ileus. Its action was striking. The distressing pain from distention disappeared, sleep followed, or, at least, the patient would become quiet instead of restlessly tossing about. Oftentimes the first dose would regulate peristalsis. Not less dangerous is that stage when, about a week later, mechanical ileus may set in as soon as the granulations between the intestines begin to grow and the adhesions commence to shrink. Intestinal atony, with its very distressing subjective disturbances after removal (of the appendix ?), is also favorably influenced. It is often astonishing how patients who are in a serious condition pick up and feel so much better after atropine. Thus, he has learned to do without morphine and opium both in the after-treatment of appendicitis and in managing it by internal measures. He has administered as much as ten mgms. in five hours without any toxic symptoms worthy of mention.

The writer is very enthusiastic in his praise of atropine in such conditions. He asserts that we have in this drug a remedy which is to be placed in the front rank with the best of our materia medica.—*Muenchener Medicinische Wochenschrift*, No. 36, 1902.—(I have employed this remedy hypodermatically in incurable hernias and in internal obstructions, and I am more than pleased with it.)

Frank H. Pritchard, M.D.

A FEW POINTS ON THE DIET IN NEPHRITIS.—Dr. Koester at the recent and fourth meeting of the Scandinavian Congress for Internal Medicine, after touching on our current ideas as to the proper diet for those suffering from nephritis, communicated the results which he had obtained in twenty-six patients from an investigation of the influence of diet as to the quantity of albumin and sediment in the urine where nephritis was present. These for some time were kept on a strict milk diet, then on milk and vegetables; later on white meat and eggs, and, finally, a mixed diet—red meat, beef soup, etc., all in certain definite quantities. Four times a day the urine was passed and examined with Esbach's albuminometer and under the microscope. The results were that no unfavorable effects could be observed to follow the mixed diet. The patients, on the contrary, felt better and grew stronger; at the same time he has seen oedema and ascites disappear while under this diet. Only in four cases did he note an aggravation from this diet. In two cases uræmia followed without the food having had any influence on its production. He concluded as follows:

Acute nephritis, or acute exacerbations of the chronic variety, should be treated with strict milk diet as long as the exacerbation lasts. In chronic nephritis one may without risk allow a mixed diet, including both red and white meat, with exception of spices and alcohol. It is unimportant whether one give red or white meat. Ascites and œdema are no contra-indication to a mixed diet if a patient desire it. At times it is of advantage to interrupt this diet, and to put the patient onto milk alone for a while.

In the discussion which followed, Dr. Aaser agreed with Dr. Koester that a strict milk diet was insufficient in chronic nephritis, and might be even injurious. He had seen patients who had been feeding on milk pick up after being allowed a mixed diet. Also, in a number of cases following scarlatina and diphtheria, he has permitted a number of patients to have bread, fish, bread and butter, and a few a little meat, prohibiting coffee and alcoholic beverages. He has never observed any unfavorable results from these foods, nor had he seen uræmia follow. On the contrary, several patients who had been drinking milk did become uræmic. Unfortunately, we know but little of the influence of diet in nephritis.

Prof. Laache wholly agreed with the conclusions of the writer, and would not be too strict with the diet in chronic cases. Acute cases have a tendency to spontaneous recovery, yet one should not forget that they may also become chronic.

Docent Sivén called attention to the end-products of albuminoids being excreted through the kidneys, while those of the carbohydrates are thrown off by the lungs and skin. As urea is a diuretic, that diet would be an ideal one which would contain least albuminoid food; in other words, fatty and carbohydrate foods. Indeed, we should try to diminish the quantity of albuminoids in the diet of nephritics, and he thinks that in the future we shall go still further. If sufficient milk be taken to cover the bodily requirements of an adult, he should be obliged to drink three to four litres daily, when he would consume as much albumin as in ordinary diet. The greater quantity of liquid increases the work of the kidneys, which excrete about half the fluid of the food. From experiments on himself he concludes that one should attempt in nephritis to keep the patient on a diet *poor in albumin but rich in fat and carbohydrates*.—*Hospitalstidende*, No. 36, 1902.—(Read Dr. Goodno's excellent article in his *Practice of Medicine* on nephritis and its treatment.)

Frank H. Pritchard, M.D.

A RARE FORM OF GIANT-CELLED SARCOMA OF THE NECK OF THE FEMUR; BEGINNING SEEMINGLY UNDER A SYMPTOM-PICTURE OF SCIATICA; FRACTURE OF THE FEMUR AFTER A SLIGHT TRAUMA.—Dr. Pels-Leusden reported at a recent meeting of the physicians of the Charity Hospital of Berlin, the interesting case of a man of 33 years of age who had, since the end of February, 1901, suffered from sciatica. He entered the hospital and remained there for some time for treatment, but Sept. 6, 1901, he was transferred to the surgical wards on account of a fracture of the neck of the left femur, which occurred after his leg had fallen from a height about as great as his bed was from the floor. He was then suddenly seized with violent pains in the left hip, and found himself unable to move his left lower limb. The excessive painfulness of the hip rendered it impossible to examine it without an anæsthetic, but the slight occasioning trauma as well as the youthful age of the patient were very

suspicious of a malignant growth in the neck of the bone. A skiagraph showed a break in the neck near the trochanters, though the head was intact and sharply outlined. In the diagram there was a cloudy diffusiveness about the neighborhood of the neck, which was laid to effusion of the blood. It was thought possible that the excessive fragility of the bone might be due to a nervous cause, yet this was excluded, as careful examination of the nervous system was negative. After seven weeks had passed there was not the slightest trace of consolidation. A second skiagraph revealed complete disappearance of the neck and a great portion of the head of the femur, as well as a substitution of these parts by a diffuse cloudiness in the skiagram. In intra-capsular fractures such a state, though in a lesser degree, may be noticed, yet only after years where a fracture refuses to consolidate, and this had occurred within a few weeks. Hence, one could only conclude that the femoral neck was the seat of a very malignant growth, which was rapidly consuming the bone. The patient was informed of the seriousness of his condition, and he agreed to an operation, even to a removal of the limb. A trial incision was made, and a dark, reddish-brown mass extruded, which both macroscopically and microscopically was recognized as a giant-celled sarcoma; the giant-cells could be detected even in the fresh specimen. As the growth had involved the muscles surrounding the capsule of the joint, exarticulation was done. The patient recovered from the operation itself, and was soon able to be up and about on an artificial limb.

Myelogenous giant-celled sarcoma usually are quite benign in their character, yet that cannot be asserted of this case, for its course was quite rapid, the growth invading not only the neighboring bone, but also destroying the capsule of the joint and involving the surrounding muscles. It was different from a myelogenous giant-celled sarcoma which does not destroy the bone but causes it to enlarge, with a great tendency to disintegrate and to form cysts; the former may even heal spontaneously, or after incision and curetting.—*Berliner Klinische Wochenschrift*, No. 38, 1902.

Frank H. Pritchard, M.D.

ANOTHER WAY TO EXTRACT A FOREIGN BODY FROM THE EAR.—Dr. A. Cuhe, in those cases of children who have gotten a foreign body into the auditory canal, and who are timid and afraid of a syringe, advises one to take a short rubber-tube, small enough to be slipped easily into the ear. The end is dipped into oil and placed against the foreign body. The physician then sucks the air out so that it adheres, and thus carefully withdraws the offending body with ease.—*La Semaine Medicale*, No. 39, 1902.

Frank H. Pritchard, M.D.

DIFFERENTIAL DIAGNOSIS OF HYSTERICAL AND ORGANIC PARALYSIS.—Dr. Buzzard, of London, asserts that those cases of paralysis in healthy persons who consciously simulate the disease are hysterical (?). Those paralysees which affect certain nerves or branches of nerves are not to be regarded as hysterical. Hysterical paralysis often disappears suddenly; it never begins with apoplectiform phenomena, but gradually develops. The area of anæsthesia is often more extensive than the organic paralysis. The face is rarely involved, and the plantar reflex is absent in the hysterical form. Babinski's *phenomène des orteils*—toe reflex—denotes an organic affection.—*Wiener Medicinische Wochenschrift*, No. 38, 1902. (J. E. Ormerod has an excellent

article on hysteria and paralytic conditions of hysterical origin in Allbutt's *System of Medicine*, vol. viii.).

Frank H. Pritchard, M.D.

TONSILLITIS FROM THE BACILLUS OF TYPHOID COMPLICATING TYPHOID FEVER.—The majority of writers regard those affections of the mouth and pharynx complicating typhoid cases as due to the impossibility of keeping these parts antiseptic, while others look on these cases of stomatitis, and especially of tonsillitis, as of true typhoid origin; that is, as due to or dependent on a direct action of the bacillus. Drs. Bendix and Bickel are of the latter opinion, and cite the case of a young woman of twenty years who, after eighteen days of fever, and while at the height of the disease, was suddenly seized with intense tonsillitis and pharyngitis so serious that tracheotomy was thought necessary at any moment. The tongue was dry, very swollen, and covered with a thick, brown and sooty coating, while each tonsillar pillar was the seat of a grayish ulcer surrounded with a reddish aureola. Similar ulcers were found in front of the epiglottis, at the root, and on each side of the base of the tongue. They seemed to resemble closely the typhoid ulcers of Peyer's patches. Cultures made from these throat ulcers yielded typical colonies of typhoid bacilli. In spite of the apparently serious nature of these lesions at the beginning they soon pursued a benign course; the patches ulcerated, and at the end of ten days they were covered with normal epithelium. There was no glandular enlargement during the whole course of the disease.—*La Semaine Médicale*, No. 38, 1902. (A typhoid fever at times may begin with an intense tonsillitis, which for some time may be the only sign of the fever.)

Frank H. Pritchard, M.D.

TWO CASES OF BACTERIURIA.—Dr. I. Rosqvist calls attention to the irregularity and changeability of the clinical symptoms from the presence of bacteria in the urine, and especially to the severity of the general condition. He observed such a case in a girl of five years who had always been well, but who from her first year had suffered from enuresis nocturna. July 2, 1901, she was suddenly taken ill with general weakness, headache, fever, which continued for several weeks. It seldom fell below 39°, indeed, usually rose to 40° or 40.7°. Later this continual fever became quite irregular. At her entrance in the Hospital for Malarial Diseases in Helsingfors, her fever was high and irregular. Nothing definite could be made out in the internal organs, the blood was sterile, spleen not enlarged, no roseola nor constipation. The urine was acid, with no trace of albumin, but it was slightly opalescent, and had a fetid and disagreeable odor. After centrifugation a few leucocytes and a great number of motile bacilli were found; there were discovered to be pure cultures of bacterium coli commune, for there was development in grape-sugar, coagulation of sterilized milk, indol-reaction of the cultures in bouillon as well as in Dunham's solution. Salol internally and vesical irrigations with 1:1000 and 1:1500 solutions of nitrate of silver were without effect, and only when $\frac{1}{2}$ –2 per cent. solutions of the nitrate were used was success obtained, which was rapid. During the last eighteen days of treatment she gained five kgms., and on November 11th she was discharged cured. Even the enuresis itself was somewhat improved. The second case was that of a woman of fifty years, who twenty years previously had a difficult labor, followed by a double parametritis, and who later had twice suffered from a

vesico-vaginal fistula. During the later years of her life she had been quite well. September 26, 1898, she was suddenly seized with a severe chill, followed by fever, headache and backache, with vomiting. When she first came under observation October 2, 1898, her temperature was 38.6° , but the next day it fell to normal. From time to time, however, at regular intervals, varying from three to fourteen days, it rose to 39° or even 40.5° . The internal organs were normal and her blood sterile. She was treated with irrigations of 2-4 per cent. solutions of argentic nitrate, and discharged cured March 15, 1899. A year later her urine was still found to be aseptic.—*Finska Läkarsällskapets Handlingar*, Bd., xliii., p. 38. (I have found the salol and copaiva comp. formula of the New York Polyclinic, in capsuloids, useful in such a condition.)

Frank H. Pritchard, M.D.

SURGICAL HINTS.—Conversation is not always very valuable in surgery, yet it is always advisable for the surgeons to stick to the anæsthetic he has always used, rather than try experiments with a new thing, and this because the anæsthetist is more important than the anæsthetic.

The period just before an emergency operation is not the one to seek to accomplish the reformation of an alcoholic patient. It is better to let him take a bottle of whisky to bed with him than to run the chances of an attack of delirium tremens at this time.

Always have some salt solution in readiness when operating in the neighborhood of a large vein, so that in case of an incision of the latter the wound may be filled with the fluid, thus preventing the entrance of air.

Remember the undue importance attached to their symptoms by neurasthenic patients, and do not be in a hurry to operate for vague conditions described by them. If not thoroughly acquainted with the varieties of this class of patients, the surgeon had best consult with a neurologist before doing any but emergency operations.

When a wound is situated in a place in which constant motion is going on, such as the canthi, or the angles of the mouth, it is always best, if possible, to avoid using stitches, as they tear out easily under such circumstances. Adhesive plaster, of collodion, will generally prove to be the best means of approximating the severed parts.

Never pass a catheter or any other instrument into the bladder without feeling that you are undertaking one of the operations in which absolute asepsis is most important, and in which its neglect may bring about the most appalling results. Catheterism must be considered as a procedure requiring as much cleanliness, delicacy and patience as any in surgery, and it is well to realize that, when taken in time, an infection of the ocular conjunctiva is trivial, compared to an infection of the bladder.

In injuries about the lower jaw, affecting one side at or above the level of the angle, as after a severe blow from a fist, there is often a slight deviation of the jaw away from the affected side. This might lead one at first to think of partial dislocation, were it not for the fact that the lower jaw can easily be pushed toward the median line. The cause lies in the fact that the muscles on the injured side are relaxed as much as possible by the patient, owing to the pain caused by their contraction after an injury.—*International Journal of Surgery*.

Herbert P. Leopold, M.D.

A SIMPLE METHOD OF STERILIZING CATGUT.—Mayo Robson describes his method of preparing catgut as follows: "I simply undo the constricting centre of each skein and reapply it loosely, thus avoiding constriction of the skein in the centre, and enabling the heated fluid to reach every part of the catgut. The skeins are then introduced into a metal cylinder, the cap of which screws on, and after the cylinder has been filled with xylol (boiling point 140° C.), the cap is screwed up very firmly, as it is quite fatal to the preparation either to allow any water to enter the cylinder, or to allow any xylol to evaporate. The cylinder is then put into the sterilizer and boiled for at least half an hour. After being thus sterilized, the catgut is stored in 5 per cent. carbolic acid solution in methylated spirit. So far as I can say, it keeps indefinitely, so that any quantity can be prepared at one time. When operating, I use the ligatures out of 1 in 20 carbolized spirit."—*British Medical Journal*.

Herbert P. Leopold, M.D.

CHRONIC PANCREATITIS.—Chronic pancreatitis as seen by the surgeon is always secondary. It is dependent upon infection extending from the intestines or the bile-passages, upon the long-standing irritation of gall or pancreatic stones, or upon the invasion of malignant disease which may be primary in the gland itself, or may extend into the gland from the duodenum or stomach. Certain toxic substances brought by the blood to the gland may set up chronic inflammation; of such are the poison of syphilis, the organism of tubercle, and, it is confidently said, alcohol. Pre-eminent among all these causes we must, without question, place cholelithiasis. Associated with, and dependent upon, gall-stone disease may be found in every grade the extension of inflammation to the gland. In the slightest cases a little thickening of the head of the gland is found; that portion nearest to the duodenum is denser and stiffer than the body or tail. In the severer cases the whole head and part of the body also may be enlarged and extremely hard and solid, feeling like a plaster cast of an enlarged gland. But in all cases the duodenal end is more profoundly affected by the changes which have taken place than is the body. The tail is only implicated in the long-standing and severer instances. During the last two years, since my attention was more especially directed to the pancreas in operations in the upper part of the abdomen, I have seen several cases of chronic pancreatitis. These illustrate the association of the inflammation of the glands with pancreatic calculus, syphilis, stone in the ampulla of Vater, stone in the common duct, and suppurative cholangitis due to stone in the gall-bladder and cystic duct.—*The London Lancet*, September, 1902.

Herbert P. Leopold, M.D.

THE ACT OF VISION.—The writer points out that but "a little over a year ago it was demonstrated that while the eyes are moving, as we look from one point to another in an ordinary complex field of view, we can distinguish none of the impressions the eyes receive." Mr. Dodge points out that in moving the eyes across the page in reading, the progress is never continuous; it is interrupted by a series of stops. We have actually no power of moving our eyes slowly; and, as it is now well known that distinct vision requires exposure to the retina for an appreciable fraction of a second, we are actually blind to all external objects while the eyes are moving, and only see during the stops.

He consoles the average reader whose envy has so often been excited by thinking of the intellectual genius who can take in two or three lines of print at a time. Such a feat must now be relegated to the lumber-room of stale miracles.

The man of exalted mental powers may be able to read very fast, but while his eyes are performing the sweep, he never takes in a single word.

More serious are those moments of blindness to the boxer or the fencer. Empirical expediency long ago developed the maxim that both should fixate the eye of the opponent. This is not merely to avoid giving cues of intended movement, but also to avoid the disastrously numerous moments of blindness which would result if one attempted to follow the motions of the opponent's hands. The writer points out an interesting physical fact which has probably not been noticed by some of our readers: "All of us see a reflection of our eyes in a mirror many times a day, but none of us ever saw his own eyes move." The fact that we can see our heads move frequently produces "the illusion that we see our eyes during a movement of the point of regard."—Raymond Dodge, Wesleyan University *Medical Press and Circular*.

William Spencer, M.D.

EYE-STRAIN AND EPILEPSY.—Gould and Bennett have examined the eyes of seventy-eight patients in the Craig colony for epileptics.

Sixty-seven out of the cases considered had astigmatism, and about one-half of the entire number of patients had unsymmetric astigmatism.

These writers state that this incidence is about twenty times as great as in ordinary patients.

The patients were fitted with glasses, and their subsequent histories will be carefully recorded.—*American Medicine*.

William Spencer, M.D.

TRAUMATIC CATARACT.—The principal factor in increase of tension after wounds of the lens is the difficulty in filtration of the aqueous, loaded as it is with an excess of albuminoid matter, due to the solution of lens substance in this fluid. In some cases when the wound of the lens is very small, and the swelling of the lens very great, the ciliary processes and the root of the iris may be crowded into the filtration angle; but if the wound to the capsule is extensive, and the swollen lens masses escape easily into the anterior chamber, the former mechanism is more noticeable.

Phenomena of hypertension due to discission, according to Fukala's method of treatment of high myopia, which often simulate acute glaucoma, give almost an experimental proof in favor of the theory of faulty filtration, due to albumin in the aqueous.—Dr. M. W. Froncoso, *Annals of Ophthalmology*.

William Spencer, M.D.

CHLOROSIS AND ITS RELATION TO THE EYE.—The writer alludes to the customary association of chlorosis with the female sex and the age of puberty, but adds that this condition is more frequent in the male sex than is commonly supposed, and that it is often seen later than the thirteenth year. A brief review of the pathology of chlorosis is given, and concludes with the following statement: "To sum up the pathology of chlorosis we must say, in view of the statement above briefly outlined, that it is an oligochromemia dependent upon a faulty hemoglobingenesis. In other words, we can call it autotoxemia, and the lesions in the fundus are the result of this toxemia."

The various symptoms and ocular conditions either directly dependent upon or aggravated by the existence of chlorosis are described in detail. The paper closes with the following conclusions:

1. Optic-nerve atrophy, papilloretinitis and pseudo-albuminuric spots can and do have a chlorosis as their causative factor.
2. Double optic atrophy associated with chlorosis may simulate brain tumor to a marked degree.
3. Headaches due to a refractive error and asthenopia are of a severer type, and are often aggravated by the chlorosis.
4. Arterial pulsation in the retina is indicative of the severity of the disease, as is also the venous pulse.
5. The fundus lesions in chlorosis are the result of an autotoxemia.
6. The prognosis in nearly every case is favorable, considering the severity of the hemic lesion, excepting in optic atrophy.
7. The foci of fatty degeneration in the retina deserve special attention, so as not to be mistaken for albuminuric spots.—George F. Suker, M.D., Chicago, Ill., *American Medicine*.

William Spencer, M.D.

THE DIFFERENTIAL LEUCOCYTE COUNT IN THE NEW-BORN.—In making numerous examinations of the blood in the new-born, Louis M. Warfield gives the following conclusions:

1. The leucocytes at the day of birth are more numerous than at any other time of normal life.
2. Nucleated red blood-corpuscles rapidly disappear from the circulating blood of the healthy infant within the first three days of life.
3. The percentage of eosinophiles varies widely in the blood of babies of the same age.
4. Myelocytes and mast-cells are only occasionally found, and are in very small numbers.
5. The percentage of large mononuclear and transitional cells is large compared to that found in the blood of adults.
6. The polymorphonuclear cells at birth are not only relatively, but absolutely increased. They begin to decrease in numbers soon after birth, and by the eleventh day of a healthy infant's life they are fewer in number than the lymphocytes, while the number of the latter variety of cell has actually increased, and the differential count of the leucocytes on the eleventh day is practically identical with the count given in the text-books as normal for the infant's blood.—*Med. Record*, Sept. 27, 1902.

W. Howard Lyle, M.D.

PERCUSSION SIGNS OF PLEURITIC EFFUSIONS.—C. H. Green.—The following conclusions are drawn:

- (1) In unilateral pleuritic effusion the heart border corresponding to the opposite side shows a marked change in position as between full inspiration and full expiration, when the patient is sitting or standing erect.
- (2) This is easily demonstrated by percussion sustained by evidence afforded by inspection and apex auscultation, and absolutely confirmed, if necessary, with the fluoroscope.
- (3) Such a range of excursion does not occur in the normal chest or in those conditions likely to be confounded with pleuritic exudation.

(4) The technique consists in percussing the free cardiac border in full inspiration, and again in forced expiration, with the patient in a standing or sitting posture, and noting the change of position. The border will be displaced outward by the expiratory movement.

(5) Percussion of the upper border of flatness posteriorly shows a well-defined rise of the fluid in full expiration coincident with the outward displacement of the heart.—*New York Medical Journal*, August, 1902.

William F. Baker, A.M., M.D.

CONCLUSIONS AS TO THE TREATMENT OF TUBERCULOUS PERITONITIS IN CHILDREN.—Roth.—(a) Tuberculous peritonitis in early life is rare in the first year, and when it occurs at this age it is almost universally fatal, as it is almost invariably a part of a general tuberculosis, and is for that reason not amenable to treatment by laparotomy.

(b) The most common age for the disease to appear is from one and a half to four years.

(c) Cases may be divided pathologically into (a) primary; (b) secondary. The secondary cases are most frequently those which are infected from the lungs, from the intestines, and from the mesenteric lymph nodes.

(d) Where the lung or any other important organ is the primary cause, the prognosis is that of general tuberculosis, and laparotomy in these cases is seldom of avail. This class of cases includes those in which there are tuberculous ulcers in the intestines. Tuberculosis of the mesenteric lymph nodes, however, as a primary cause, does not mean that the cases are necessarily fatal, or that they cannot be relieved by laparotomy; therefore, where the tuberculosis is primarily in the mesenteric lymph nodules, laparotomy is indicated, as we have no means of determining in these cases, excepting by trial. Where the tuberculosis is primarily in the peritoneum, laparotomy is essentially indicated, and is often followed by complete cure.

(e) There is a distinction to be made between these primary cases, in which, first, there are many thick adhesions and advanced tuberculous lesions not accompanied by the presence of much fluid, and, second, where the tuberculosis is represented by miliary tubercles of the peritoneum, with ascites.

In the first class of cases laparotomy should be performed, although the prognosis is not so good. The second class is the most favorable for recovery by operation, and laparotomy should be performed without question.

Taking into consideration that an exploratory laparotomy, is a safe procedure in comparison to non-operative treatment, and considering that merely an exploratory operation sometimes cures the disease, is it not better to operate at once and allow the patient the benefit of the chance?—*Archives of Pediatrics*, September, 1902.

William F. Baker, A.M., M.D.

HISTOLOGY OF THE GASTRIC MUCOSA.—(Einhorn.)—After discussing the subject very fully he comes to the following conclusions:

(1) The secretory functional disturbances of the stomach are not based on a primary change in the mucous membrane of the stomach. They rather produce, if they last for a longer time, lesions of the mucosa of greater or less extent.

(2) The diagnosis of carcinoma of the stomach may, under speedily favor-

able conditions, be made from a piece of gastric mucosa if a direct invasion of the gland substance by epithelial cells can be observed.

(3) Therapeutically attention must be directed toward the improvement of the general body state, and only secondarily by means of special measures against any secretory anomalies that may be present.—*The American Journal of the Medical Sciences*.

William F. Baker, A.M., M.D.

THE ETIOLOGY AND DIFFERENTIAL DIAGNOSIS OF HODGKIN'S DISEASE.—Ely (Philadelphia) reviews the literature of Hodgkin's disease, and reports a case of his own. He is strongly inclined to agree with Sternberg and Musser that the disease is of tuberculous origin, and presents a mass of presumptive evidence to that effect. He considers that in any case proofs must be regarded as insufficient and experiments incomplete without inoculation in the eye-chamber of the guinea-pig and awaiting the appearance of tubercle in the iris. He suggests the following points for the purpose of differential diagnosis :

1. Lymphosarcoma, small-celled sarcoma of lymph-glands, involves organs rather than glands, and not the general involvement of one group of glands after another. It is sarcoma, and usually adherent to the skin. It rapidly invades surrounding tissues, fuses with them, and destructive ulceration soon appears.

2. Local benign lymphomata. This is a simple persistent hypertrophy of certain glands of benign nature, without extension.

3. Syphilitic adenitis will be diagnosed by the late symptoms, by diseased bones, nose and throat, keratitis, periostitis, and by the therapeutic test.

4. From leukæmia, by the enlarged spleen, hæmorrhages, diarrhœa, and by the blood examination.

5. From chronic or acute adenitis, time reveals its true nature, essentially a disease of infancy, slow increase, has a definite exciting cause, and terminates in resolution or suppuration.—*Phila. Med. Journ.*, Oct. 18, 1902.

F. Mortimer Lawrence, M.D.

SEPTIC ENDOCARDITIS CURED BY INTRAVENOUS INJECTION OF CREDE'S SILVER.—Klotz records the case of a woman of 27 in whom the attack was ushered in with acute tonsillitis. About a month after the attack began, when she was first seen, she was evidently in a severely septic condition, with signs of multiple joint-involvement, and with the physical signs of endocarditis. She was given an intravenous injection of 9 cgm. of Crede's silver in 1 per cent. solution. This was repeated several times, always with good effect. Almost immediately after the silver injections were instituted the temperature fell, and continued to decline. The patient rapidly passed on to ultimate entire recovery. The cardiac signs completely disappeared.—*Deutsche Med. Woch.*, July 17, 1902.

F. Mortimer Lawrence, M.D.

THE INFLUENCE OF THE RÖNTGEN RAY UPON SARCOMA.—Coley (New York) reports several cases treated with the X-ray, and concludes that :

1. Results in cases thus treated prove that the Röntgen ray has a remarkable inhibitory action upon the growth of all forms of malignant disease, and this is especially true of sarcoma.

2. This action, in many cases of even far-advanced and inoperable malig-

nant disease, may result in the total disappearance of tumors, often without any breaking down of the tissues, the new growth being apparently absorbed.

3. Whether the patients have been cured, or the disease has been merely arrested, to reappear at some future date, is a question that time alone can decide.

4. Recent observations and experiments upon the various forms of carcinoma and sarcoma prove that an agent, supposed to be of value only in a very limited class of superficial epitheliomata, promises to be as great or even greater in practically every variety of cancer.

5. While at present there is little evidence to show that deep-seated tumors in the abdomen and pelvis can be cured or benefited by the Röntgen ray, there is still some reason to hope that with improved apparatus, or with greater knowledge and skill in using the apparatus we now have, even these cases may be benefited.

6. The Röntgen ray has a very marked influence upon the pain of nearly all types of malignant tumors, causing entire relief in the majority of cases.—*Medical News*, Sept. 20, 1902.

F. Mortimer Lawrence, M.D.

A COLLECTIVE INVESTIGATION OF THE VALUE OF CREOSOTE CARBONATE IN PNEUMONIA.—Van Zandt (New York) addressed the following inquiries to over 70 physicians who had used the drug and report 1130 cases treated:

1. Do you believe creosote ever aborts pneumonia? To this question 37 physicians, reporting 762 cases, answered "yes;" 15, reporting 187 cases, said "no."

2. Do you believe the majority of cases are mitigated by it? To this 57 physicians, reporting 1022 cases, answer "yes," while only 2, reporting 10 cases, say "no."

3. Have you ever found cases which, having plenty of time, are entirely uninfluenced by it? To this 23 say "yes," and 30 "no."

The aggregate death-rate was 5 per cent., in contrast with the ordinary mortality of 25 per cent., and even these comparatively few deaths were chargeable largely to complications. The report appears to afford additional evidence that the treatment of acute pulmonary inflammation with creosote is a remarkable life-saving discovery.—*Med. Record*, Oct. 15, 1901.

F. Mortimer Lawrence, M.D.

DIRTY FINGER-NAILS AND TUBERCULOSIS.—Two German investigators (Preisich and Schutz), noting that children frequently put their dirty fingers into the mouth or nose, examined the dirt contained under the finger-nails of 66 children between 6 months and 2 years of age. Cultures were made and guinea-pigs inoculated. Many of these died of an acute infection, so that the presence of tuberculosis could not be proved. Stained tubercle bacilli were demonstrated in 14, or 21 per cent. of the 66 patients examined. All but 5 of the patients gave some history of tuberculosis in the family. In most cases the infection comes from bone or gland tuberculosis, the bacilli drying in the dust which reaches the finger-nails. When these bacilli enter the mouth they may cause pulmonary or abdominal tuberculosis. Many other pathogenic bacteria are formed in dirty finger-nails, and this may explain the frequency of enlarged cervical glands in children.—*Berl. Klin. Woch.*, May 19, 1902.

F. Mortimer Lawrence, M.D.

PARATYPHOID FEVER.—Since the general introduction of the Widal test, a great deal of interest has been aroused in cases presenting the clinical picture of typhoid fever, but which do not show the presence of the Widal reaction, and from the discharges of which neither the typhoid nor the colon bacillus is obtained, but instead bacilli resembling both of them in some respects. Coleman (New York), reviewing the investigations concerning these bacteria (*American Medicine*, September 27, 1902), acknowledges that as yet it is a little premature to attempt fine distinctions, and regards it as sufficient to recognize two main groups, viz. :

1. *The Paracolons*.—A group of bacilli, the members of which are culturally alike, but constitute several distinct species, some of which may give rise to typhoidal symptoms in man.

2. *The Paratyphoids*.—A distinct species, culturally unlike the paracolon bacilli, which causes typhoidal symptoms in man.

The majority of the members of the typhoid-colon group of bacilli are pathogenic for man or certain of the lower animals. The various infections both in man and the lower animals exhibit much similarity in that the manifestations are largely of a gastro-enteric type, with or without constitutional symptoms. Pathogenicity in man has been established for certain of the intermediates. Broadly speaking, there are three types of infection, viz. :

1. Typhoid type, caused by paratyphoid bacilli and certain of the paracolons.
2. Epidemic meat-poisoning type, caused by *bacillus enteritidis* and its allies.
3. Psittacosis type, caused by *bacillus psittacosis*.

In addition to these three types Greenbaum has suggested that febrile jaundice may be caused by one of the intermediates. More recently Eckhardt has obtained a positive Widal reaction in two cases of Weil's disease in as high dilution as 1 : 1000. The author states that the Widal reaction is often positive in jaundice from any cause, but that in these cases it was not due to the icterus alone, as it persisted, even at the same strength, after the icterus had disappeared. He argues that Weil's disease may be a peculiar abortive form of typhoid fever.

Coleman questions whether the term "paratyphoid" should be applied to fevers caused by these organisms. When it is considered that infection with paratyphoid bacilli is manifested by symptoms practically identical with typhoid fever except for Widal reaction, that there are differences (biologic and in serum reactions) even among the paratyphoid bacilli themselves (β -paratyphoids), and that bacilli of the enteritidis type may at times produce typhoidal symptoms, it seems no more advisable to make a clinical subdivision of these cases than of the cases of pneumonia or infective endocarditis which may be due to one of several different micro-organisms. Moreover, typhoidal symptoms may be produced by Petruschky's *bacillus fecalis alcaligenes* (the author states that it was obtained from the fæces of the patients suspected to have typhoid fever), and yet this bacillus is not an intermediate.

These considerations make it necessary to abandon the idea of the *specificity* of typhoid fever, broadening the scope of its etiology to include these several organisms—*bacillus fecalis alcaligenes* (?), *bacillus typhosus*, *bacillus paratyphosus*, and certain members of the paracolon group (β -paratyphoids). The only reliable criterions for diagnosis are absence of the Widal reaction in proper dilution (not less than 1 : 40) with a positive reaction against a known paratyphoid bacillus or the recovery of a paratyphoid bacillus from the blood, urine, stools, or complicating inflammatory process.

F. Mortimer Lawrence, M.D.

THE ETIOLOGY OF INFANTILE SUMMER DIARRHŒA.—The *New York Medical Record* (September 13, 1902) discusses editorially the recent discovery in the etiology of summer diarrhœa in infants made by Duval and Bassatt. These investigators have studied a series of cases of this condition, and have come to the conclusion that it is an infection with the *bacillus dysenteric* (thuja). Mr. Duval had formerly worked under Flexner in the study of the acute dysentery of adults in this country, and was therefore thoroughly conversant with the methods of isolating this bacillus and familiar with its appearance. How far this intimacy with the dysentery bacillus may have influenced the investigators in their judgment in the matter remains for other bacteriologists to determine.

In over forty cases the bacillus was demonstrated. It was present in large numbers in the acute cases, while in the subacute and chronic it was scarce. The bacillus was not found in the stools of healthy infants or in other diseases.

The *Record* states that the authenticity of this report is vouched for by Prof. Welch, of Johns Hopkins University. Should these facts be substantiated by further investigations, one of the most vexed problems in pediatrics will have been solved.

C. Sigmund Raue, M.D.

THE DISSEMINATION OF TYPHOID FEVER.—From a study of the influence of soil, fabrics and flies in the dissemination of enteric fever, Firth and Horrocks conclude:

1. That there is no evidence to show that the enteric bacillus, when placed in soil, displays any disposition or ability to increase in numbers, or to grow upward, downward, or laterally.

2. That the enteric bacillus can be washed through at least 18 inches of soil.

3. That the enteric bacillus is able to assume a vegetative existence in ordinary sewage-polluted soil, and survive therein for as long as 74 days.

4. That the presence of organic or nutritive material in the soil appears to have no influence on the existence of the bacillus.

5. That an excess or great deficiency of moisture in the soil appears to be the dominant feature affecting the possibility of recovering the enteric bacillus from the soil.

6. That from fine, dry sand the enteric bacillus can be recovered on the 25th day.

7. That from fine, moist sand the enteric bacillus cannot be recovered later than the 12th day, probably because it is washed down into the deeper sand layers by the liquids added.

8. That the enteric bacillus appears to die out rapidly in peat.

9. That from ordinary soil kept damp by the addition of rain water, the enteric bacillus can be recovered up to the 67th day.

10. That from a similar soil kept damp by the addition of raw sewage, the enteric bacillus is recoverable up to the 53d day.

11. That when the addition of diluted sterile sewage is made to a similar soil, the enteric bacillus is recoverable up to the 74th day.

12. That in a similar soil, after a heavy rainfall, the enteric bacillus at once disappears from the surface layers.

13. That from a similar soil, allowed, after inoculation, to become so dry as to be readily blown about as dust, the enteric bacillus can be recovered up to the 25th day, and that enteric infective material can be readily translated from dry soil by means of winds and air currents.

14. That in a sewage-polluted soil, recovered from beneath a broken drain, the enteric bacillus is able to survive up to the 65th day.

15. That from a piece of khaki inoculated with an emulsion of enteric bacilli, and then allowed to become dry, the organism is recoverable up to the 74th day.

16. That from a piece of blue serge similarly treated, the enteric bacillus is recoverable on the 78th day.

17. That from a piece of khaki fouled by liquid enteric fæces and then allowed to dry, the micro-organism is recoverable on the 17th day.

18. That the enteric bacillus is able to survive in surface soil an exposure to 122 hours of direct sunshine, extending over a period of 21 consecutive days.

19. That from a piece of infective serge the enteric bacillus is recoverable after the fabric is exposed to 50 hours of direct sunshine, spread over a period of ten days.

20. That ordinary house flies can convey enteric matter from specific excreta or other polluted material to objects on which they may walk, rest, or feed; that such infected material appears to be attached not only to their heads, but also to their legs, wings, and bodies.—*British Medical Journal*, Sept. 27, 1902.

F. Mortimer Lawrence, M.D.

SERUM TREATMENT OF EXOPHTHALMIC GOITRE.—In the *Muenchener Medicinische Wochenschrift* (May 20, 1902), Schulte reports the case of a woman, æt. 49, who presented the typical symptoms of Basedow's disease, and was treated with a preparation of the serum of sheep from whom the thyroid glands had been removed. There were marked psychical symptoms before the administration of the serum, but these soon disappeared, and in less than two months the patient was discharged entirely cured. The subjective symptoms disappeared, the size of the neck was reduced, the frequency of the pulse was diminished, and the tremor disappeared; but the exophthalmos persisted. No disagreeable results attended the use of the serum.

In the same number of the same journal Goebel, starting, as did the investigator just cited, with the theory that the disease depends upon hyperfunction of the thyroid glands and the symptoms are due to excessive production of thyroïdin, acted upon the proposition that rational treatment should consist in an effort to reduce the production of this organic iodine compound. As the thyroid gland is the only organ in which this substance is formed, the milk of animals whose thyroid glands have been extirpated should contain none of it, and he determined to treat cases of exophthalmic goitre with the milk of such animals. He removed the thyroid glands of goats, with no result as far as the animals were concerned, except that they became somewhat savage, and then treated patients suffering with all the characteristic symptoms of exophthalmic goitre with the milk from these animals. One patient who was so weak that she could not walk was able, in a few weeks, to get about, and the circumference of her neck had diminished, she gained in weight, the pulse was reduced to 90 beats per minute, all subjective symptoms had ceased, and some hard nodules that had been felt in the goitre had disappeared. Another patient, a man who fell and struck the back of his head so hard that he became unconscious, developed the symptoms of Basedow's disease, but subsequently became well again without medication. (These results seem far from conclusive.)

F. Mortimer Lawrence, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY O. S. HAINES, M.D.,
with the collaboration in German literature of C. Sigmund Raue, M.D.

CHRONIC GASTRITIS.—There is a group of symptoms that we have met a number of times in patients suffering from this ailment that will bear repetition because of the prompt relief afforded by a simple prescription. The patients have been men. Some have been made ill by the cold mid-day lunch habit. Others have used tobacco to excess, or have indulged, unwisely, in alcoholic stimulants. They all complained that at intervals during the day, or even at night, they would be seized with a severe pain in the abdomen, which seemed to draw the abdominal walls inward, towards the spine. In a few moments the mouth filled with clear water, and, if the patient leaned forward, a large amount of clear water rose and was expectorated. Sometimes a stream of clear water would run from the opened mouth. Vomiting was exceptional. Belching or abnormal taste or burning was also exceptional. Associated with these symptoms is usually an obstinate constipation. It is astonishing how quick a single dose of plumbum, 6x trituration, will relieve these distressing phenomena; and the relief is permanent, if an occasional dose be administered for a short time. We feel confident that this train of symptoms will be seen by physicians generally, and we wish that they would try the plumbum under such circumstances.

THE SINGLE-DOSE PLAN.—We have of late years been very favorably impressed by the effects of single doses of the proper medicament, especially in subacute or chronic ailments. By this we do not mean "a dose,—and wait six weeks." We mean a single dose, placebo every four hours, and a report every few days. There can be no doubt of the truth of the statement that has been made so often,—that repeated or frequent doses of a remedy often interfere with the full curative action of that remedy. And it would seem desirable that the profession test this matter very thoroughly, for it is a very important matter, both to the practitioner and to his patients.

CALENDULA.—Dr. Chandler Weaver remarked, quite recently, that the virtues of our calendula were scarcely appreciated as they deserved to be. He instanced the soothing effects of calendulated sterile water after bladder-washing. If, after the bladder has been thoroughly washed, a small quantity of calendulated warm water be introduced into the bladder and allowed to remain there until passed naturally, the patient will experience much more relief and comfort than if this be not attended to.

PILOCARPINE IN SALIVATION AND HYPERIDROSIS.—The *Central Anzeiger* prints the following interesting observations concerning the action of pilocarpine in salivation and hyperidrosis. The writer recommends small doses (five drops of a one to one thousand solution), and adds, apologetically, that this dosage has nothing to do with homœopathy, but that the action of the drug in the small dose recommended can be explained upon purely physiological grounds, although it is exactly opposite to the action of large doses of the drug. He also uses the drug in minute doses in the night-sweats of phthysical patients. Furthermore, he cautions against the use of large doses, as under these circumstances an aggravation sets in. To a homœopath there appears a trace of humor in this attempt to belittle the law of similars, although the shade of malice detectable is, of course, to be deplored.—*Allgemeine Homœopathische Zeitung*.

OUR ATTITUDE TO DRUGS.—Dr. Walter Jordan's therapeutic paper upon this subject was cleverly analyzed and criticized in October *Homœopathic Review*, London. It seems that Dr. Jordan thinks that it was no sin for the homœopath to use doses infinitesimal in his calculation, nor drugs which, in the observation of others, were barren of results. It was a sin for homœopaths to say that every condition of disease must be cured by treatment based on a theoretical system. Now the truth of the matter is that Dr. Jordan is, himself, a pretty fair homœopath, only he is not aware of that fact. He thinks that it is "only by a determination to know what a drug can do in the the human body, and what is the condition of the body into which we introduce the drug, that we can avoid falling into purely haphazard and fruitless methods." That is what most homœopaths think. Further on he says that "the same drug, we all know, may have exactly opposite effects in small and in large doses." The homœopathic school has been banking pretty heavily upon that thought for about a hundred years. He thinks it was upon this fact "that homœopathists built up their heresy." He is correct in this; for it was upon that fact, and a few other facts, that everybody ought to know by this time, that our science was erected. Homœopathy is a "heresy" built upon *facts*. It is unique in that respect. Dean Stanley said, "You may, by establishing a single truth, put to flight a hundred heresies." Dr. Jordan might have annihilated homœopathy by simply *proving* that the law of similars is untrue. He did not do this, however. He is quite a believer in small doses,—one minim doses of liquor arsen., for example; or half-minim doses of vini ipecacuanha, with which he has obtained some of his "happiest results in catarrhal states of the mucous membranes." The allopathic profession admits that small doses cure conditions similar to those produced by large doses of the same drug; why not make them admit the "reason why," before we join them.

THE KEYNOTE SYSTEM OF PRESCRIBING.—The keynote system of prescribing is only efficient under two conditions; first, that it is peculiar and prominent; and, secondly, that it is corroborated by other peculiarities or characteristics. The keynote is only the first note or tone of the scale in which the piece is written, the tone of the chord, and would make no harmony without other notes accompanying it. This characteristic condition or symptom guides the prescriber to the remedy (or remedies) for study and comparison, and when other conditions or symptoms corroborate its relation to

the individual case, happy results will follow its prescription. So says Dr. W. A. Yingling in *Medical Arena*. It is very seldom that a single keynote or characteristic is, of itself, a sufficient basis for a prescription. At times, fine results will follow; but these are only happy guesses. To the homœopathic prescriber, guessing should be the rare exception, and never the rule. We might say that these keynotes stand, like guide-posts, along the way. They generally point the therapeutic traveller in the right direction, but one can seldom tell, from them, how near he really is to his destination.

VERIFIED SYMPTOMS.—Henry L. Stambach, M.D., thinks that we should each emulate the example of Constantine Hering, who, having frequently verified, by observation and experience, a given remedy, published his facts to stimulate those who came after him. It is questionable, we think, whether such verifications make very interesting reading for the average magazine reader. Perhaps we are in error, but it makes no difference. The fact remains that these verifications are veritable nuggets of gold for those who are students of the *Materia Medica* and for those who are building our *Materia Medica*s. And it would be a splendid thing if this sort of work was generally performed by the homœopathic profession. In a very few years it would place our *Materia Medica* upon an even firmer foundation of facts. In the *Pacific Coast Journal* the author mentions a number of verifications, which will repay careful reading.

NATRUM SULPHURICUM.—Rheumatism, whether due to uric acid or not, when there is a decided aggravation from *dampness*, finds in *natrum sulphuricum* a valuable remedy. The symptoms of this drug are remarkably similar to those of sciatica and other affections of the hip-joint, and it has proved efficacious in such cases, when the characteristic modality was present. Any neuralgic or rheumatic affection brought about by living in a damp house, or by working continuously in a damp atmosphere, will often be cured by this remedy. The same holds true in catarrhal conditions, no matter what mucous membranes are involved. In bronchial catarrh the remedy is most useful when asthmatic symptoms prevail, with great dyspnoea and depression. The cough is either dry, or there may be a glairy expectoration. The symptoms are worse at night; relief is obtained by sitting and by holding chest with both hands. One of the most prominent uses of this remedy is in acid dyspepsia, especially when there is heartburn and flatulence. Gastric derangements characterized by acidity call for the *natrum sulphuricum* very frequently. It produces pronounced liver symptoms, and is useful in subacute and chronic hepatitis. The region of liver is sensitive to touch, to a jar, on sneezing, or upon coughing. The liver feels as if tense and about to burst open. An important modality being worse lying on the left side.—A. C. Cowperthwaite, in *N. A. Journal*.

THE TREATMENT OF LOCOMOTOR ATAXIA.—The Chicago Clinical Society devoted the evening of September 29th to the discussion of the treatment of locomotor ataxia. Dr. P. S. Clark presented a paper upon this subject. He recommended as among the first and most important requisites, *rest*. If the case is severe, rest in bed for six or eight weeks; then moderate exercise. Next measure of importance is Frankel's method of re-education. This stands without a peer in the treatment of ataxia. Massage and electricity are valuable. Static electricity applied to the spine is considered to be an ex-

cellent adjuvant. Dry cups along the spine the author thought useful. Dr. Clark called attention to the necessity for individual treatment of each case, and spoke very positively against the habit of routine prescribing. At the end of his paper he refers to some homœopathic remedies which may be found useful. *Argentum nitricum* produces every symptom of this disease. The spinal sclerosis, the gastric crises, pain, atrophy of optic nerve, the paralysis of the bladder, and loss of sexual desire and power; all these are among its prominent symptoms. This remedy stands foremost in the treatment of tabes in both schools of medicine. (We used to wonder why such an intensely homœopathic similimum could not cure the disease. But the reason is plain. No power or remedy on earth can restore a sclerosed cord. The lesion of the disease cannot be cured. We believe, however, that we have evidence of the power of this remedy to retard the progress of the disease, and even to bring the morbid process to a standstill if administered early in its course.)

Zincum metallicum, or in combination, as zinc pic. or zinc phos., also occupies the front rank as a remedy in this disease. The most important indication for the zinc is the pronounced formication of the lower extremities. Picric acid is valuable in asthenic individuals, where sexual desire is pronounced. The double chloride of gold and sodium is a remedy of the first class when melancholia, with suicidal tendencies, insomnia, tremor and loss of appetite are prominent symptoms. In syphilitic cases, with caries of bones and arterio-sclerosis, it is also recommended.

Of course, stress is laid upon the usefulness of iodide of potassium in ascending doses, when there is a marked syphilitic history.

Belladonna, *berberis*, nitric acid, *gelsemium*, sulphur, alumina, *secale* and *nux vomica* are all suggested for further study, but no definite indications for their use are mentioned. In this paper the author brought out very clearly the nature of this affection as revealed by more recent investigations, showing that it is not a nervous disease in the sense usually comprehended; but that the lesions in and around the blood-vessels are of primary importance, the lesions of the neurosis being determined by local interference with the blood supply. There seems now some good ground for belief that locomotor ataxia depends upon a chronic auto-intoxication, and it is possible that the future will offer us a radical change in the method of treating it. The pains of locomotor ataxia sometimes baffle the best efforts of the physician. Dr. Clark finds that, sooner or later, an anodyne becomes indispensable. He has a favorite tablet upon which he relies. One of these tablets, if taken as soon as the pains come on, often brings speedy and entire relief. If one does not, another may be administered in half an hour until three have been taken. This pain tablet contains three and a half grains of acetanilid, one grain of soda bicarb., one-third grain of codeine, one-half grain of *caffein. cit.* Dr. Clark closed by saying that he had really tried faithfully to apply the indicated remedy to the crises of pain, and must admit that he had not been successful in that line. The report of this meeting may be found in *Clinique* for October 15th.

THERAPEUTICS OF HYPERCHLORHYDRIA.—A most interesting paper by Dr. Halbert, upon the treatment of this affection, may be found in October *N. A. Journal*. He enumerates the internal remedies about as follows:

Magnesium Phosphate.—Overcomes the gaseous eructations, the burning pain in the stomach, the abdominal distention, and cares for the constipation to a considerable extent.

Robinia.—From a symptom standpoint, should be thought of above all other remedies. Pre-eminent we find: A low-spirited mental state. Constant sour eructations. Vomiting of an intensely sour liquid. Sharp, burning pains in the gastric region, worse when stomach is empty; relieved by taking more food. The author gives the third potency, repeats it frequently, and thinks it should be given for a long time, in order that its full effects shall be obtained.

Chininum Arsenicosum.—A favorite remedy of the author in many stomach diseases. Indicated when this disease seems to be an alternation of hyperacidity and a decrease of acid. There is thirst, yet water and food disturb.

Argentum Nitrate.—One of our most useful remedies in later stages of affection, when the rapid digestion ceases and the peristaltic power of stomach is lost. Food remains too long in the stomach, as the result of dilatation. Gases are excessive, and are ejaculated from stomach with force. The stomach is in a neurasthenic state, and the patient is, in every sense, a "nervous dyspeptic." Should be given in freshly-made aqueous solution.

Hydrastis.—Should be considered when the hyperchlorhydria is associated with an atonic dyspepsia. Particularly useful in old people, when the acid condition has been preceded by chronic gastric catarrh.

Grindelia Robusta.—Its action is remarkable in many obstinate cases of stomach disease. It is indicated when hyperæmia of the gastric membrane is persistent. Dr. Halbert has used it in many cases of hyperchlorhydria, when asthmatic and other neurotic characteristics have been paramount, with gratifying results.

Orexine Tannate.—A remedy of recent use, that has given the author good results in old and obstinate cases of hyperchlorhydria, or, rather, in gastric perversions which follow hyperchlorhydria. In his experience, it is most frequently called for when acid deficiency ensues after a hyperchlorhydria. There is a tardy gastric emulsion, undigested food irritates the stomach, and both a muscular and mucous atonicity appear. The first and second decimal triturations, frequently administered, have been found useful in such baffling conditions.

There is much in this paper that will repay a careful reading, especially the author's suggestions as to diet and the use of various adjuvant treatments.

ARSENICUM IODIDE.—When we find a patient suffering from inflamed and unhealthy glands and a scaly eruption, which is very proliferous, in addition to the general arsenicum symptom picture, we should prefer the *iodide of arsenic*. A girl of 8 years, whose father had syphilis before she was born, was cured by the 6x trituration. Her mother saved the fish-like scales which had been rubbed off her body during twenty-four hours, and they measured nearly one ounce. Almost all her lymphatic glands were involved.—Geo. Royal, M.D., in *N. A. Journal of Hom.*

FERRUM PICRICUM IN TREATMENT OF WARTS.—Dr. A. Puller, in *Homœopathic World* (October), ascribes to this remedy in the third decimal tincture the power of curing warts. He mentions, in substantiation of this claim, the case of Miss H., aged 35 years, who had two large and painful warts upon the little finger of her right hand. Three similar growths were upon the middle finger of the left hand. These had existed for three years, and after removal by electric cautery had reappeared within one month. The warts were sensitive, aching much during the night. She was of that type,

dark-complexioned and bilious, which has been said to be especially susceptible to the action of ferrum picricum. After six months' treatment her warts disappeared and her general health was also much improved. Patients frequently wish to try medicinal treatment for warty growths, in preference to the usual surgical procedures, and this hint of Dr. Puller's may be of use to us. There is confidence in the efficacy of thuja, internally and externally, in such cases; yet the latter remedy is by no means certain in its action.

ONE WAY OF ABATING A NUISANCE.—Dr. W. C. Cooper, of the *Medical Gleaner*, in a little natural history talk, calls attention to the fact that when a shark sees anything which he thinks ought to be abated,—and his nuisance-list includes everything from a "man overboard" to a tin can,—he proceeds to abate it by a method peculiarly his own,—that is, he swallows it. It seems that the shark is a wise fish in this respect,—that he puts objectionable things out of sight and evidence in the quickest and most direct method. Dr. Cooper hopes that the eclectic school will not imagine that he is referring to any attempt to amalgamate the two schools, although it is not difficult to follow the trend of his thoughts.

INTERSTITIAL NEPHRITIS.—We saw a very pretty result following the administration of nux vomica in various potencies, in a case of interstitial nephritis, quite recently. The man was 60 years of age, and had been kept under the influence of this remedy, in various potencies, for upwards of a year. The remedy was first chosen for attacks of vertigo upon first movement in the morning. Any attempt to rise from bed produced severe vertigo. The head felt enlarged. When standing, the patient felt as if taller than usual. Constipation and gastric disturbances were also present. The urine is now of a specific gravity of 1016, and no albumin nor other signs of chronic nephritis were found. The relief of his symptoms was prompt. We are aware of the difficulties in the way of a claim that this disease can be cured, yet we sometimes feel that chronic Bright's disease is more or less amenable to homœopathic therapeutics. We wish some one would write a good paper upon this subject.

A PROVING OF SAPONDRIA OFFICINALIS.—Dr. Schier relates the following symptoms experienced by him and others in a proving of saponaria officinalis:

Rumbling in the abdomen; urging to stool; pain in the hypogastrium. Somnolence and depression; vertigo and vomiting. Nausea induced by turning the head or moving eyes. Headache, aggravated by the slightest attempt at mental exertion and free motion.

Eyes: the ciliary nerves were affected, and vision became disturbed. Deep stitches in the eyes (suggesting glaucoma).

Stiffness of the nape of the neck. Face pale. Tongue coated posteriorly; papillæ swollen. Salivation. Collection of mucus in throat; dysphagia. Tonsils swollen; the trigeminus is affected.

Dull pain in the region of the heart; pulse slow and weak; general muscular atony.

Saponaria was much used by the physicians of the eighteenth century. At the present day it is a popular domestic remedy in Russia, and in Sweden it is used in the form of a tea for old syphilitic affections.

Saponin, the glucoside of saponaria, is also found in senega, polygala, sarsaparilla, silena inflata and other plants. It is practically inert, but when

administered hypodermatically, it produces an erysipelatous local inaction and a number of general symptoms.—*Allgemeine Homöopathische Zeitung*, Aug., 1902.

TREATMENT OF PERTUSSIS.—In the treatment of pertussis, without complications, Dr. F. L. Babcock says he has used but few remedies. These are cuprum met., coral. rubrum, magnesia phos. After having tried many other remedies, he has generally returned to coral. rub. or mag. phos. These two, either singly or in alternation, have been his sheet-anchors, and the results have been all that could have been desired. He has always held that fresh air, free from vapors of every kind, was one of Nature's best restorers. He has never been favorably impressed with the virtues of crude drugs vaporized in the sleeping apartment of the patient. The confidence of this writer in the two remedies mentioned seems to be unbounded; and, as it is based upon the results of his experience during several epidemics, it is worthy our careful consideration. (Mass. Hom. Med. Soc.).

CANNABIS INDICA POISONING.—Dr. R. O. Butterfield relates, in *The Critique* for September 15th, a case of cannabis indica poisoning. The pulse of the patient was very weak and slow. Although the house was well warmed, she was cold, and sat chattering between spells of silly laughter. Her temperature in axilla was 96. At first, she labored under much mental excitement. Was very self-conscious. Laughed over her own inconsequential remarks. Thought them very witty. Later her mind was more quiet, and she was drowsy. She asked the time every few moments, although the clock stood in plain sight. She remarked upon occurrences that happened a long time before, although in reality they had occurred but a few minutes previously. She walked across the room, and remarked that she had been walking for hours. Space seemed to be increased. She thought the piano in the parlor was blocks away. She was very dizzy all night long, and had to be assisted in walking or when rising from a chair. She had a severe headache. The sides of her head felt as if they were being pressed outward. This sensation was accompanied by ringing in the ears. Her eyes were blood-shot, she appeared to be looking into the distance, her face wore a silly expression. Her mouth was dry, with a very little frothy saliva. Constant desire for small quantities of water. There was a constant complaint that there was not enough air in the room, and a constant desire to take deeper breaths. During the night there were frequent unsuccessful urgings to stool. At first she suffered from severe paroxysms of pain in the region of the heart. She clutched at the heart and writhed, while the cold perspiration appeared upon the face and body. After two of these attacks (which resembled angina pectoris) she suddenly collapsed and the pulse disappearing, she was revived by a hypodermic injection of nitro-glycerine and the use of the Faradic current. This pain about the heart lasted until next day; and, having the band sensation present, she was given ten drops of cactus lx, which relieved her. Three nights later she had a recurrence of these heart pains. It must be stated that the patient had suffered from such attacks previous to taking the cannabis. The dose given by this patient was sixty minims of fluid extract of cannabis indica.

THE MEDICAL MILLENNIUM.—Dr. J. Wylie Anderson thinks that the homœopath who *claims* to be a simon-pure follower yet gives calomel in ten-grain doses, and morphia for every pain, has done more injury to the cause than the man who is honest, yet claims to be only an allo-homœo-electro-

path; in other words, a mongrel. He believes that the medical millennium will have arrived when medical men cease to be bigots, are honest with themselves and with others, according the same privileges to others as they demand themselves. When truth and not hypocrisy prevails. When men observe the golden rule of doing to others as they would be done by. When they prove all things and hold fast to that which is good. And we agree that when all things therapeutic are regularly proven, before being adopted into the armamentariums of physicians, it will be about time to amalgamate. Just at the present time, however, it would seem more judicious to make the "line of demarcation" a trifle more distinct, instead of effacing it altogether.

THE LINE OF PROGRESS.—It has been the dream of some adherents of the homœopathic school, says Dr. Clarke, of London, that by uniting allopathic science with homœopathic art, something very much finer than Hahnemann ever dreamed of would be evolved. The therapeutic world has, however, seen the production of this cross, and has had no particular cause to be enamored of the breed. If there is one thing more certain than another in relation to all arts, it is this: *Concentration is the price of excellence.* So, Dr. Clarke claims that the reason why homœopathy has not made even more progress in the world of therapeutics is the fact that homœopaths have not adhered conscientiously and strictly to the homœopathic point of view. The language of drugs is symptoms; symptoms which they can produce, and symptoms which they can remove. A drug talks to us in pains and aches, unusual sensations, motions, appearances; in disordered functions, in altered tissues. Diseases speak to us in exactly the same language. The idea of some that they can improve on Nature by translating this natural language into the ever-fluctuating language of pathology and nosology is erroneous. Hahnemann taught us how to let diseases talk to drugs, and he rendered to the world the essential service of throwing open, to any one who chose to accept it, the freedom of the *materia medica*. Dr. Clarke does not approve of those of us who will not give a case of pneumonia a drug that has not, to our knowledge, produced the actual state pathologists recognize as pneumonia. He thinks that any drug may be called for in any case of disease, if the peculiar symptoms of the drug are evolved by the disease. If we give up this freedom of the *materia medica*, then good-bye to progress in homœopathy. (*Hom. World*, London.)

ACNE.—As it occurs in young people, may, if recent, be cured by belladonna if the patients are full-blooded; by pulsatilla, if they are pale and slender. The connection of the affection with sexual evolution probably explains the value of these remedies. In more chronic cases, which yet are acne simplex, sulphur is indispensable. If suppuration has occurred, hepar is more curative. Dr. Deschere thought that kali brom. rarely failed in simple acne of the face and upper portion of the body. The 1x or 2x dilution or one grain of the salt, three times daily, cures the eruption, especially in nervous females, without reference to puberty. Acnea rosacea yields to the iodides of sulphur or arsenic, and to carbo animalis.

Dr. Arcularius praises cicuta in pustular acne. It has been thought that an excess of both sugar and salt in the diet will aggravate acne, if it will not actually cause the acneiform condition. This point should be borne in mind, as also the relationship of natrum mur. as a curative medicine of great value.—*The Principles and Practices of Hom.*, by Dr. Richard Hughes.

THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER.

A Medical Newspaper.

EDITED BY

HERBERT P. LEOPOLD, M.D.

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Physical Diagnosis.—Diseases of the Thoracic and Abdominal Organs. A Manual for Students and Physicians. By Egbert Le Fevre, M.D., Professor of Clinical Medicine, and Associate Professor of Therapeutics in the University and Bellevue Hospital Medical College; Attending Physician to Bellevue and St. Luke's Hospitals; Consulting Physician to Beth-Israel Hospital, etc. Illustrated with 74 engravings and 12 monochrome plates. Lea Brothers & Co., Philadelphia and New York. 1902.

The author has brought together in this volume of 450 pages a valuable collection of details as to the physical signs significant of the various diseased conditions which may occur in chest and abdomen. Physical diagnosis, as the author says, is now taught at an early period in the curricula of the medical schools, and this circumstance has rendered it essential that he give a brief account of the morbid changes in the different organs. As a supplement to this

he has elaborated, to a degree unusual in works of this scope, the explanation of *why* these signs occur. All those who have had experience in teaching medicine will agree that this is necessary in order that the student may clearly understand that the signs are dependent on certain changes in structure or function, and are not infallible indications of this or that disease. In this, we believe, lies the chief merit of the book. It lacks the internal evidences of careful clinical study, analysis and deduction which render Cabot's iconoclastic work so admirable; but for students, to whom it is addressed, Le Fevre's work should prove a safe and reliable guide. The illustrations, most of them diagrammatic, are well chosen, and the book shows the fine topography and binding which characterize all the utterances of its publishers.

Progressive Medicine.—A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics in the Jefferson Medical College, Philadelphia, etc., assisted by H. R. M. Landis, M.D., Assistant Physician to the Out-Patient Medical Department of the Jefferson Medical College Hospital. Volume III. September, 1902. Diseases of the Thorax and its Viscera, including the Heart, Lungs and Blood-vessels—Dermatology and Syphilis—Diseases of the Nervous System—Obstetrics. Lea Brothers & Co., Philadelphia and New York. 1902.

The present volume of *Progressive Medicine* opens with a review of the year's progress in our knowledge of thoracic diseases, by Wm. Ewart, M.D., F.R.C.P., of London. Pneumonia and the recent modifications in its treatment are discussed with considerable detail, but the bulk of the report deals with tuberculosis, the British Congress on Tuberculosis of last year furnishing many of the observations. Bronchial and pleural diseases are considered, and the heart and blood-vessels receive due attention. William S. Gottheil, M.D., of New York, contributes a review of recent investigations and experiences in dermatology and syphilis, concerning which he is a recognized authority. His opinion, incidentally expressed, of radiotherapy is interesting. He believes that it will find a place in the treatment of certain skin diseases, but that it has great dangers and disadvantages, and its employment should at present be left in the hands of experts. It is significant that one of the pioneers in its use obliges all patients to sign a release for all damages before he makes a single examination or application. William G. Spiller, M.D., of Philadelphia, records the advances in our knowledge of the nervous system and its diseases; and Richard C. Norris, A.M., M.D., also of Philadelphia, contributes a valuable *résumé* of matters obstetric. All in all, *Progressive Medicine* continues to furnish the best retrospect of our advancing knowledge of the medical and surgical sciences.

A Guide to the Practical Examination of Urine, for the Use of Physicians and Students. By James Tyson, M.D., Professor of Medicine in the University of Pennsylvania, and Physician to the Hospital of the University, etc. Tenth edition, revised and corrected. With a colored plate and wood-engravings. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut Street. 1902. Price, \$1.50 net.

With pardonable pride the author, in his preface to the tenth edition, alludes to the fact that over 25,000 copies of the book have been sold. The reasons for such a remarkable success are obvious to anyone who glances over the 300 pages which constitute the volume; for the theory has been reduced to a minimum, and instead, plain directions as to chemical and microscopical methods of examination are given, together with a concise *résumé* of the clinical significance of the results attained. The present edition reveals comparatively few changes of importance. The author, in common with a great majority of clinicians, con-

tinues to regard heat, controlled by nitric or acetic acid, as affording the most delicate and reliable test for albumin. Of the various copper solutions for ascertaining the presence of sugar, he still prefers Fehling's, because he has not found the various modifications of the latter any more satisfactory or reliable. All of the more important tests are given, however. The urinary deposits are described, and their microscopical appearance pictured in a series of well-chosen, though not elaborate, illustrations. A section is devoted to the analysis of urinary calculi, and in an appendix are given forms for recording the urinary examination, and tables for the conversion of the metric into the English system of weights and measures.

The Homœopathic Medical Society of the State of Pennsylvania met in annual session in Hahnemann Medical College, Philadelphia, on Tuesday, September 23, 1902. The opening session was called to order by the President, R. P. Mercer, M.D., at 10 A.M. After an invocation by the Rev. Webster H. Pearce, of the Park Avenue Methodist Church, an address of welcome was delivered by O. S. Haines, M.D., President of the Homœopathic Medical Society of Philadelphia. A response was read by R. P. Mercer, M.D. On motion of Dr. Moreland, calling of the roll was dispensed with. The report of the Treasurer was read and adopted. The President appointed Drs. Gilbert, Haines and Perkins to serve on the Board of Censors until the regular Board should be present. The report of the Corresponding Secretary was rendered and accepted. On motion, the name of Dr. S. C. Rosseau was continued on the roll without dues. The resignation of Dr. H. I. Jessup was presented and accepted. A communication from the Saturday Night Club of Microscopists, requesting that they be permitted to conduct the session on Tuesday evening, was read, but the request was not complied with, as the President ruled that it would be out of order according to the programme adopted. The Trustees reported having held the annual meeting required by law, and recommended that, when the proposed amendments came before the Society, the members vote to have the dues stand at five dollars. On motion, the order of business was suspended, and the proposed amendments to the by-laws were taken up. A motion to adopt Article 9 was carried. A motion that the proposed amendment to Article 7 be laid on the table was carried. The report of the Board of Trustees was adopted. That of Committee on Organization, Registration and Statistics was accepted. Report of Committee on Legislation was carried over until later in the session. None of the delegates appointed to attend other State societies made any reports. On motion, it was decided that the custom of appointing delegates to other State societies be abrogated. A motion that no member be eligible to hold office in the Society who is in arrears more than two years was carried. On motion, it was decided that the nomination and election of officers be made the order of business for Thursday, September 25th, at 4 P.M. A resolution to increase the number of members of the Publication Committee was presented. Motion to adopt was lost.

Section on Ophthalmology, Otology and Laryngology.

A paper, "The Effect of Hypertrophied Tonsils upon the General Health," was read by H. S. Weaver, M.D., and discussed by R. E. Tomlin, M.D., and C. H. Hubbard, M.D.

A paper entitled "The Treatment of Mastoiditis," by G. A. Mueller, M.D., was read by Dr. R. L. Piper.

A report of "A Case of Retro-Bulbar Neuritis, with Unusual Complications," by H. I. Jessup, M.D., was read by Dr. H. S. Weaver.

In opening the discussion the latter said: "I have seen a few cases of retro-

bulbar neuritis due to tobacco poisoning and alcoholic excesses, and the only remedy I used in these cases was strychnia. Prior to the recommendation by one of the Philadelphia oculists of strychnia hypodermically in the temple, my results had never been very satisfactory. I was very much gratified on reading that article. At that time I was treating a case, and immediately started injections of strychnia in the temples, and was gratified to see the case begin to yield. I don't know why strychnia should be more beneficial hypodermically than by mouth, but it is a clinical fact that it has a more decided action. The first few days I gave a sixtieth of a grain, then a fortieth of a grain, then down to a thirtieth, then down to a twentieth of a grain. The method of introduction is simple. Clean the temple thoroughly; take as small a hypodermic as possible, as small an amount of water as possible, and rub thoroughly, to avoid cellular inflammation. Use it in one temple one night and in the other temple the following night, and keep this up for a number of days."

In response to a question by Dr. Thomas Welsh as to whether the patient was allowed to continue alcoholics and tobacco, Dr. Weaver stated that he prohibited smoking entirely, and alcoholics as far as possible. Meeting adjourned at 12.20 P.M.

The afternoon session commenced at 3 P.M. with the

Section of Obstetrics.

"A Case of Ectopic Pregnancy in which Child Lived, with Rupture of the Broad Ligament, full term, operation thirteen months after death," was reported by John E. James, M.D.

In discussing the paper, T. L. Chase, M.D., commented on the importance of diagnosis in cases of ectopic pregnancy, and related a case in which symptomatic treatment for a supposed digestive difficulty was persisted in for weeks, until finally grave symptoms led to consultation and operation. Dr. Betts emphasized the importance not only of diagnosis, but of speedy operation. Dr. T. J. Gramm reported a case of supposed normal pregnancy that went on to term, had so-called evidences of attempted labor, and when no cervical dilatation occurred, was supposed by her attendants to have miscounted the time. Finally she fell into the hands of a medical man, Dr. Byrnes, who recognized her condition. The child lay outside of the uterus, and was removed successfully by operation. Dr. A. Korndorfer, Jr., stated that an important diagnostic point, when rupture has taken place into the broad ligament, lay in the ability to palpate the broad ligament. As the only similar condition is ovarian cyst, exclusion of the latter and of intra-uterine pregnancy renders the diagnosis positive.

A contribution, "Leucorrhœa in Pregnancy," by Dr. Kline, was read by title. A paper on "Pelvimetry" was read by A. Korndorfer, Jr., M.D.

Dr. T. L. Chase, opening the discussion, emphasized the need of recognizing the pelvic contraction when the patient first engages the *accoucheur*, not when labor has begun. Dr. T. J. Gramm referred to the surprising results of the Johns Hopkins investigations, whereby it was shown that a large percentage of American women have contracted pelvis. Dr. Matthew Williamson referred to the large size of the infants in some cases.

Section of Gynecology.

A paper on "Appendicitis Complicating Pregnancy and Parturition" was read by B. F. Betts, M.D. Dr. R. E. Tomlin reported a case similar to that of Dr. Betts.

"The Curette as a Surgical Factor," by J. H. Thompson, M.D., was read by Dr. Gramm.

Dr. Martin stated that he preferred to prescribe symptomatically, rather than have curettement done, as soon as the patient had a temperature of 101° or 102°.

Dr. Betts emphasized the importance of good drainage. Dr. Martin suggested that if the patient lie upon her side drainage would be better. Dr. T. J. Gramm insisted upon the necessity for eliminating the danger of continued infection.

Three papers, "A Case of Pseudo-Hermaphroditismus Masculinus with Elephantiasis Vulvæ," by R. E. Tomlin, M.D.; "Symptoms of Ovarian Irritation," by Anna M. Johnston, M.D.; and "Cystitis," by Evelyn S. Pettit, M.D., were read by title. Meeting adjourned until 8.30 p.m.

September 23, 1902. Evening session, 8.30 p.m. A paper on "Secondary Degeneration of the Cord Following Spinal Fractures," illustrated with lantern slides, was presented by J. J. Tuller, M.D.

Dr. Weston D. Bayley, in discussing the paper, urged more thorough study of the cord and its lesions by the profession at large. The study of these degenerative lesions is really the study of the anatomy of the tracts. He brought forward the question of the permanency of spinal injuries, narrating a remarkable case of complete paraplegia of both sensory and motor nerves up to the waist-line, with subsequent muscular atrophy and reaction of degeneration, which ultimately recovered. He also urged that the neuro-pathologist instruct the general practitioner as to the preservation of cord specimens for examination.

September 24, 1902. Morning session, 10.15 a.m. The minutes of the previous session were read and approved. The Board of Censors reported favorably on the following names: Dr. Taylor, Dr. Edward Steele Haines, Dr. Alfred G. Smith, Dr. W. Weaver, Dr. John F. Hunsicker, Dr. J. E. Bellville, Dr. Ernest L. Clark, Dr. John M. James, Jr. The report was accepted and the candidates were elected.

Section of Podology.

The first paper was entitled "Some Hints in the Education of Children, Suggested by the Physiology of the Nervous System," by W. H. Bigler, M.D. It was discussed by Dr. A. C. Clark, who criticised modern educational methods for giving a smattering of many things rather than any one thing well. Education means the ability to acquire knowledge. Dr. Middleton expressed himself as opposed to the rote system of learning.

"Modern Methods in Infant Feeding" was discussed in a paper by C. S. Raue, M.D.

Dr. Middleton favored the old-fashioned breast-feeding. Dr. Dunning commented on the difficulty of securing a suitable wet-nurse. Dr. Martin, in opposition to the views expressed by the essayist, favored the use of condensed milk. Dr. E. L. Clark upheld the views expressed by Dr. Raue. Dr. Tomlin urged that water be given to infants more freely. Dr. Boileau did not believe that mother's milk should be set aside for any milk-formula, and had also seen good results follow the use of condensed milk. Dr. J. N. Mitchell, in closing the discussion, agreed with the essayist in his opposition to mechanically modified milk.

"The Modification of Cow's Milk, and the Effect of Various Substances upon the Attenuation of the Curd," was the subject of a paper by C. W. Simons, M.D. It was not discussed.

"Epilepsy in Childhood: A Case Cured," was presented by Isaac Crowther, M.D. It was not discussed.

Section of Surgery.

"Do We Operate Early Enough in Appendicitis?" was discussed by W. B. Van Lennep, M.D. (See page 820.)

Dr. W. C. Goodno, in opening the discussion, said: "I don't know, Mr. Chairman, that I need to say more than that I heartily agree with the views announced by Dr. Van Lennep in regard to early operation. I have not always

had such an opinion ; indeed, I used to procrastinate, as many do still. I used to publish my cases of appendicitis cured by medicine, but I have been gradually forced, against my will, to change my practice in accordance with my views, and to operate for appendicitis as soon as the diagnosis is made, providing the diagnosis is made clear enough. I believe, in some cases, it is better to operate in interval. One may approach a time when it is possibly better to wait, but when a case has been promptly diagnosed, operation should come as quickly as possible. I think a great many doctors feel that this is a sort of a surgical craze, that a great many surgeons employ the knife, and that this is a fad with them. It is a great mistake. There are surgeons of this sort, of course, but I am sure the majority of our surgeons of experience and standing are men who are thoroughly conservative. I know that a great many times the writer of this paper has asked me to see a case of appendicitis, and has asked me the question, 'Should I operate?' So you see they are not so anxious to operate as some may think ; and I know Dr. Haines had to almost club Dr. Northrop to operate some time ago, and now he wishes he had operated sooner. That is no criticism, of course, upon Dr. Northrop. It was a very difficult question as to whether the operation should be done or not. Surgeons who are thoroughly conservative and careful do not want to make mistakes and operate upon some that should not be operated upon. I don't see how we can expect very much result from medical treatment. There are only two ways to do any good. One is by the employment of homœopathic remedies ; indeed, no others seem to be of any value for the improvement of nutrition and to fortify the system, and in that way to enable the system to stand off the infection. The other method is the administration of drugs which destroy these organs and lessen toxæmia. This appears to be of little or no value. I don't see what we are to expect of remedies other than to help in controlling the symptoms early in the case. If any one will simply study carefully the anatomy of the subject and the pathology of the subject, I think it will soon be apparent that practically nothing can be hoped for from remedies. The appendix is, anatomically, a rudimentary organ, maybe contracted, constricted, with retention and imperfect outflow of blood which cannot be affected in any way by any medicine. The cases that get better under medicine, or rather Nature, are those in which the appendix has not, as Dr. Packard puts it, "involved." In the great majority of cases it simply relieves the patient for a time, and in a little while there is another attack, and another, or a patient is troubled by chronic symptoms, and ultimately must be operated to be cured.

Dr. Van Lennep spoke of luck and of men changing their opinions. "The change of opinion is due to the increased knowledge of appendicitis, not an improved run of luck. But we are getting better acquainted with appendicitis and better able to diagnose it. The difficult problem, it seems to me, is to determine, in any case of appendicitis, whether we are dealing with one of those slight catarrhal attacks which will pass off in a short time, or dealing with an appendix already gangrenous. I have looked into the belly a good many times, and seen an appendix gangrenous in part or in whole, when it had been a very serious question whether we ought to operate or not. The only safe means is to operate all these cases at once, as soon as diagnosis can be made."

Dr. H. L. Northrop expressed views in complete agreement with those already expressed. Dr. T. L. Chase favored early operation, and referred to cases in which it alone could have saved life. Dr. Isaac Clothier expressed his pleasure in the paper.

Dr. W. B. Van Lennep, closing the discussion, said : "There is very little more for me to say, except, perhaps, to explain my position. I don't believe

any member who has known me can accuse me of over-zealousness to operate. I have followed a safe conservatism, but have been driven to my conclusions by medical men. They have told me this must be so; it is the only safe method. It is not only my opinion, but that of many others, that catarrhal appendicitis causes more deaths than anything in connection with the disease. It is a distinctly surgical disease, just as is concussion of the brain, bowel obstruction, or strangulated hernia."

"Rectal Examination: Its Importance and Technique," was the title of a paper by Dr. T. L. Adams. (See p. 837.) Drs. Moreland, Steele, Crowther, and Ashcraft, in the ensuing discussion, laid particular emphasis upon the necessity for examination in every case presenting rectal symptoms.

September 24, 1902. Afternoon session, 3 P.M. Dr. Maddux, chairman of the Committee on Legislation, reported having written the Governor an urgent protest against the appointment of a gentleman on the State Board of Medical Examiners who was not a member of this Society, and that his name had been withdrawn, and that the prospects were excellent for having a generous sum of money appropriated for the establishment of a State asylum for the insane. The report was accepted.

The Bureau of Surgery continued its report. "Is Post-Operative Drainage Necessary in Suppurative Peritonitis?" was the title of a paper by G. M. Christine, M.D.

Dr. J. E. James expressed his opposition to attempted drainage of the pelvic cavity. Dr. T. J. Gramm stated that the general trend of surgical opinion is that drainage has not proved as successful as was anticipated for conditions deep in the pelvis. Dr. T. L. Chase believed that the value of drainage was limited to small pus-collections.

Dr. Christine, in closing, said: "The last case which I drained was a fulminating case of pus in the abdominal cavity, free, and I put several yards of gauze in. I made a counter-opening, put a large drainage-tube through, packed in the gauze through the original incision, and had that abdomen irrigated every three hours with saline solution. It took about two and a half weeks to get all the gauze out. I felt sure, on removing the tube on the second day, that I had secured practically no irrigation whatever. The lymph had grown around and fastened around the tube, and I had simply passed water through the tube. Every part of the gauze was dry and almost in original form. Originally iodoform, it came out as iodoform."

"The Surgical Treatment of Posterior Displacements of the Uterus" was the subject of a paper by T. L. Chase, M.D. It was not discussed. Papers on "Epithelioma of the Skin," by E. M. Gramm, M.D.; "Some Observations on Anæsthesia," by J. W. Hassler, M.D.; "Significance of Rectal Pain," by R. W. Martin, M.D.; and "Homœopathy and Surgery," by H. P. Leopold, M.D., were read by title.

"Some Remarks on Some Gall-Stone Cases and Complications" was read by H. L. Northrop, M.D.

Dr. W. B. Van Lennep, in discussing the paper, said, "What little I might have to say in connection with this admirable paper would be simply to make the question more interesting to the surgeon. In regard to the advisability of removing a gall-bladder, Parke has taken the ground that the gall-bladder should be treated the same as the appendix. I can readily understand how removal would be advisable were infective disease, cholecystitis, manifest. But the disadvantage of universal removal is found in the fact that we get such admirable results after drainage of the gall-bladder. Many cases are on record in which the operator has opened the gall-bladder, examined the gall-ducts, and found no stones, and in spite of that fact there was, after draining the

gall-bladder, entire disappearance of the symptoms. The majority of these cases of biliary trouble are due to catarrh of the gall-ducts and gall-bladder, and are very much benefited by drainage. In regard to the question of incision to get at the gall-bladder, and particularly the gall-ducts: Within the last few months Mayo Robson has suggested an incision which I have carried out a half-dozen times, by which we are able to turn the liver out over the abdomen, cutting through exactly the middle of the right rectus muscle. There is practically no hæmorrhage. This incision is carried up onto the chest, between the ensiform cartilage and the rib border, taking it upward instead of downward, as heretofore. This gives us complete access to both gall and cystic, and even hepatic ducts. I have been able to get at these ducts and remove calculi without the least difficulty."

"A Report of Two Unique Cases of Strangulated Hernia, with Operation and Recovery," by J. L. Peck, M.D., was not discussed. "A Brief Résumé of Recent and Improved Methods in the Treatment of Genito-Urinary Disease," by T. L. Ashcraft, M.D. (See page 721), was not discussed.

Section of Materia Medica.

"Carbolic Acid" was the subject of a paper by G. W. Smith, M.D. Dr. Charles Mohr, opening the discussion, stated that the indications for carbolic acid in scarlet fever were similar to those for belladonna. He favored more thorough proving of the drug. Dr. Tomlin testified to the clinical value of the remedy. Dr. Smith suggested that we make use of the experience of the dominant school in seeking to determine the action of carbolic acid. "The New Pharmacopœia Put to the Test" was the title of a contribution by Dr. Charles Mohr. It was discussed by Dr. A. P. Bowie, who highly commended the work.

September 25, 1902. Morning session, 10 A.M. The Bureau of Materia Medica continued its report. "The Law of Similars Illustrated by A Study of *Cocculus Indicus*," a paper by Edward Cranch, M.D., was read by title. "Some Clinical Proving," by Theo. M. Johnson, M.D., was read by Dr. Sureth, and briefly discussed by Dr. H. Biermann. "X-ray Therapy and Its Relation to Materia Medica," by R. T. White, M.D., was read by Dr. Sureth. It was not discussed. "Further and More Scientific Proving of Drugs," a paper by Theo. Sureth, M.D., was not discussed.

Section of Sanitary Science.

"The Climate of Guadalajara and its Vicinity" was described by Pemberton Dudley, M.D. The discussion was limited to a few remarks by Drs. Boileau and Coe.

Section of Clinical Medicine.

"Kidney Inflammation," by H. Biermann, M.D., drew from Dr. Thomas Welsh some interesting comments as to the effects of methylene blue and sodium salicylate on the kidneys. Dr. Hill had seen benefit follow the use of prussic acid in cases presenting offensive urine. Dr. Biermann had never seen ill-effects from the administration of methylene blue in two-grain doses. "Clinical Experiences in the Treatment of Pain," a paper presented by A. P. Bowie, M.D., was discussed by Drs. Tomlin, Byron Smith, Mercer, Strong, Dunning, Godschall, Clark, Goff, Hill, and Yale. The question of palliation by physiologic remedies was raised, and the majority acknowledged the occasional necessity for a resort to such measures. "Some Points on Insanity" were detailed by Anna C. Clark, M.D., and discussed by Dr. W. D. Bayley and Dr. A. C. Clark, both of whom urged the value of remedies selected on

symptomatic grounds. "A Preliminary Report upon the Homœopathic Action of *Cratægus Oxyacantha* from the Clinical Standpoint" was presented by C. S. Haines, M.D., and briefly discussed by Dr. E. R. Snader. "Croup" was the subject of a practical paper by E. H. Hill, M.D. It was discussed by Dr. Tomlin, who referred to the popular belief in amber beads. Dr. Starr related a case relieved by bromine, and Dr. H. S. Weaver recalled others' recommendations of that remedy. Dr. Bowie had found *kali bichromicum* the remedy most frequently indicated, but had had some favorable experience with bromine. Dr. Godschall, Dr. Byron Smith and Dr. Platt also contributed to the discussion.

September 25th. Afternoon session, 8 P.M. "Some Observations of an Old Practitioner," by J. A. Bullard, M.D., was not discussed. "Epilepsy; Its Varieties, Diagnosis and Treatment," by S. G. A. Brown, M.D., was read by title, as was "A Clinical Case," by Dr. Dinsmore.

The Board of Censors reported favorably on the following candidates: Isaac W. Hysinger, M.D., Horace Furnum, M.D., W. K. Adams, M.D., George I. King, M.D. Report accepted and candidates elected. A resolution presented by Dr. A. P. Bowie, instructing the Legislative Committee to secure the reappointment of a homœopath on the State Pharmaceutical Board was carried. On motion by the Secretary, a vote of thanks was extended to the Homœopathic Medical Society of the County of Philadelphia for the entertainment provided for the State Society. On motion, a unanimous vote of thanks was extended to the presiding officer for the able manner in which he conducted the 28th session of the Homœopathic Medical Society of the State of Pennsylvania.

The election of officers resulted as follows: *President*, O. S. Haines, M.D.; *First Vice-President*, W. A. Seibert, M.D.; *Second Vice-President*, Theodore Sureth, M.D.; *Recording Secretary*, Geo. B. Moreland, M.D.; *Corresponding Secretary*, Edward M. Gramm, M.D.; *Treasurer*, Ella D. Goff, M.D.; *Necrologist*, Chandler Weaver, M.D. *Censors*, to take the place of T. H. Carmichael, M.D., Geo. W. Smith, M.D.; to take the place of E. H. Pond, M.D., declared vacant, Anna C. Clark, M.D. *Trustees*, to take the places of Drs. D. P. Maddux, Z. T. Miller and E. M. Gramm, whose terms expire, O. S. Haines, M.D., D. P. Maddux, M.D., and J. A. Bullard, M.D.

On motion, a vote of thanks was extended to Hahnemann College for the use of the building. Invitations to hold the next session in Scranton and Easton were presented, and, on ballot, Scranton was selected as the next place of meeting. Dr. Horace B. Ware presented the following resolution: Proposed amendment, in Article 7, Section 1. The Homœopathic Medical Society of the State of Pennsylvania can only accept an invitation for a location for annual meeting when same is presented by a regularly organized homœopathic medical society.

A vote of thanks was extended to the press of Philadelphia for the active part they had taken in reporting the proceedings. Adjournment at 5 P.M.

Hahnemann College of Philadelphia opened its doors on Tuesday, September 30th, with a full enrollment of students. As usual, there was a large number of matriculates attracted from other schools by the remarkable facilities for practical work afforded by the Philadelphia institution. The clinical work during the present session has been so extended that the greater portion of the senior students' time is spent in hospital, dispensary or clinical laboratory.

The Homœopathic Medical Society of Chester, Delaware and Montgomery Counties held its quarterly meeting in Philadelphia on October 14th, and in lieu of listening to a paper by Dr. W. B. Van Lennep, occupied the front seats at his surgical clinic.

The Philadelphia Medical and Surgical Society held its regular monthly meeting on the evening of Wednesday, Oct. 15th, in Room 600, Professional Building. Dr. E. R. Snader entertained those present with a demonstration of the methods of chest examination.

The William B. Van Lennep Clinical Club held its stated monthly meeting on October 7th, in the office of Dr. F. C. Benson, in the Professional Building, 1833 Chestnut Street. Two notable papers were presented, that by Dr. Benson on "The X-ray in the Diagnosis of Fractures," and that by Dr. Augustine Korndorfer, Jr., on "The Value of Pelvic Measurements." Those present were: Dr. J. E. Bellville, Dr. F. C. Benson, Dr. G. H. Bickley, Dr. W. D. Carter, Dr. W. D. Culin, Dr. C. J. V. Fries, Dr. D. B. James, Dr. A. Korndorfer, Jr., Dr. F. M. Lawrence, Dr. H. P. Leopold, Dr. W. H. Lyle, Dr. C. S. Raue, Dr. S. W. Sappington, Dr. J. J. Tuller, Dr. H. S. Weaver, and Dr. W. A. Weaver.

A Musicale for the Benefit of the Medical Department of the Hahnemann Hospital Dispensary, under the patronage of Mrs. Clarence Bartlett, Mrs. D. Wilson Chambers, Mrs. William C. Goodno, Mrs. Agnes L. Lawrence, Mrs. Samuel A. McDougall, Mrs. Charles Platt, and Mrs. William B. Van Lennep, was held at the residence of Dr. F. Mortimer Lawrence, 1601 Girard Avenue, on Friday evening, October 10th. The attendance was large, and the considerable sum realized will be used to more completely equip the medical department for thorough clinical work according to modern methods.

Personals.—Dr. W. W. Verner (Hahnemann, '01), who accompanied the Baldwin-Ziegler expedition in its search for the North Pole, has returned in good health, and will spend the winter in post-graduate work in Philadelphia.

Dr. A. P. Powelson has located at 102 Convent Avenue, corner of 148th St., New York City.

Dr. G. C. Jenkins has recently passed through an attack of typhoid fever, but is now perfectly recovered, and again attending to his practice.

Dr. W. F. Hoey, of Frederica, Del., was a recent and interested visitor to the Hahnemann Hospital clinics.

Dr. Percy A. Tindall, who has spent the last three years in Washington, D. C., two years in the hospital and over a year with the eminent oculist, Dr. W. R. King, has returned to Philadelphia, and is at present located with his father, Dr. Van R. Tindall, where he will devote his time to diseases of eye, ear and throat.

Dr. Bernard E. Bigler has located at 1425 Spruce Street, Philadelphia.

Dr. Thomas S. Dedrick's home-coming to his home in Washington, N. J., after four years and three months spent in the far north, was made memorable by an enthusiastic demonstration by his townspeople, followed by a banquet. In a recent letter to the editor, Dr. Dedrick says: "When the reasons are known for my remaining north last year, it will be no reflection, I assure you, on old Hahnemann or my profession."

Dr. William O. Forbes announces that he has opened an office at 242 Central Avenue, Hot Springs, Ark.

Dr. Chas. Gatchell, secretary of the American Institute of Homœopathy, has become a member of the faculty of Hahnemann Medical College and Hospital, Chicago, Ill.

Dr. Charles W. Gessler, of 1332 South 5th Street, has been seriously ill for several weeks past, but is now improving rapidly.

Dr. Robert J. McNeill has opened an office at 6043 Germantown Avenue, Philadelphia.

Dr. Ralph Deming is located at 6612 Germantown Avenue, Philadelphia.

Dr. Otis D. Stickney has located at 123 N. 19th Street, Philadelphia.

Dr. C. C. Shepard, H. M. C., 1901, has located at La Mars, Iowa.

Dr. A. J. Huselton has located at 232 North Sixteenth Street, Philadelphia.

Hours: 8 to 11 A.M. and 6 to 8 P.M.

Dr. Alban Spooner has returned from an extended sojourn in Vienna, and has opened an office at 149 North Fifteenth Street, Philadelphia.

The Homœopathic Medical Society of the County of Philadelphia extends a cordial invitation to the physicians of Philadelphia and vicinity to attend a post-graduate evening clinic to be given by Dr. Leon T. Ashcraft, assisted by Drs. Wm. C. Hunsicker, R. J. Abele, F. J. Douglas, and M. Rendell, on Thursday evening, November 13, 1902, at 9 o'clock, in the amphitheatre of the Hahnemann Hospital. The subject will be, "The Modern Treatment of Genito-Urinary Disorders." Homœopathic therapeutics will receive its full share of attention, and we feel sure that it will prove to be a pleasant and profitable evening for all who attend.

Removals.—Dr. D. B. Hunt announces his removal from 159 Madison Avenue, to 41 West 82d Street, New York.

The Chicago office of the Dow Portable Electric Co. has been removed to room 1200 Monon Building.

Messrs. Boericke & Tafel have removed their pharmacy, that for many years has been located at 117 S. 13th Street, Philadelphia, to larger and more commodious quarters at 125 S. 11th St.

Dr. W. Howard Lyle has removed to 1435 Girard Avenue, Philadelphia. Office hours: Until 11 A.M.; 5 to 8 P.M. Telephone, 2-44-17 D.

Dr. Thomas Matlack has removed to 2356 East York Street, Philadelphia. Hours: 8 to 10 A.M. and 6 to 8 P.M.; Sundays, 8 to 10 A.M. and 1 to 2 P.M.

Practice for Sale.—A \$2000 practice in a village of 1500 in northern Ohio. No real estate. Reason for selling, ill-health. Address, "Practice," care of HAHNEMANNIAN MONTHLY, Phila., Pa.

Washington Letter.—Dr. Corry is, we are glad to note, again able to be out and attending to practice. Dr. L. E. Rauterberg has had him under his professional care.

Dr. L. E. Rauterberg has removed his office from 510 Fifth Street, N. W., to "The Mount Vernon Apartments."

Dr. H. H. Hawxhurst has returned to the city after a fortnight vacation in Connecticut.

Dr. F. A. Gardner and family have returned from Vineyard Haven, and are again established at 1018 Fourteenth Street.

Dr. Bishop has gone to New York City to take some special courses in the New York Post-Graduate School. The doctor expects to return here later in the winter.

Dr. Copeland was in Washington for a few hours on October 9th, on his way west for Philadelphia, where he presented a paper before the American Orthodontal Society.

Dr. L. D. Wilson has returned, after a month's sojourn at Atlantic City.

Dr. Z. B. Babbitt is on a visit to the oil-fields of Texas on business.

Dr. Charles B. Gilbert will present a paper on "Recovery or Cure" at the forthcoming meeting of the Washington Homœopathic Medical Society.

Dr. Wm. H. Heran has entirely recovered from his recent attack of enteric fever, and is again attending to his practice.

Dr. Ralph Jenkins has returned to town, after a summer spent chiefly at his cottage at Monterey, in the Blue Ridge Mountains of Pennsylvania.

Dr. M. M. Moffitt, who spent the summer on the Great Lakes, is again at his office.

Health Department.—Dr. William C. Woodward, Health Officer of the District, has submitted estimates to the Commissioners for the appropriations he deems necessary for his department for the coming fiscal year, beginning July 1, 1903. Among other important features mentioned is an appropriation to begin work on the proposed Municipal Hospital; that Congress be requested to provide the necessary funds for medical inspection of public schools; that a public bath-house be established, and that a bacteriological laboratory be instituted in connection with the Board of Health.

Pure Food Legislation.—The opposition to the Hepburn bill, which has been before Congress for the past fifteen years, promises to be so slight in the coming session that its passage is confidently expected. An attempt will also be made to amend the law authorizing the Secretary of Agriculture to forbid the importation of any food prejudicial to health; so that it will read, "or food-products, the sale of which is forbidden in the countries where they are manufactured." This, for the reason that our lack of federal law on the subject renders the United States a dumping-ground for goods which cannot be sold in the place where they are manufactured, bringing to us all the misbranded and doctored compounds of the world.

Preservatives in Butter.—The Commissioner of Internal Revenues has decided that the addition of basic acid preservatives in limited quantities to fresh butter for the purpose of preventing rancidity will not subject such butter to a tax of 10 cents per pound imposed upon adulterated butter.

Enteric Fever in Washington.—For the week ending October 4th there were 79 new cases reported, total being 340 under treatment, 35 cases discharged during the week, and 7 fatalities.

The water generally in use in Washington comes from the Potomac, the intake being at Great Falls, 16 miles northwest of the city, some 50 miles below the mouth of the Shenandoah River. Frequently, after heavy rains, the water is heavy with sediment, and even muddy. The installation of a filtration plant has long been agitated, but as yet Congress has failed to appropriate the necessary funds. Regulations of the milk supply of the city are more severe than in any other city, and are rigidly enforced by the health department of the district. It is the general belief, however, that the present epidemic of typhoid is due to milk, and an effort is being made to locate the source.

Changes in Army Medical School.—Col. Calvin De Witt, Assistant Surgeon-General, U. S. A., is detailed, as President of the Faculty of the Army Medical School, to relieve Col. Charles Smart, Assistant Surgeon-General, U. S. A.

Surgeon-General Forwood Retires.—Brigadier-General William H. Forwood, Surgeon-General of the Navy, closed his military career September 6th by operation of law, on account of age. He was relieved of his duties at the head of the medical department of the army by Brigadier-General Robert M. O'Reilly, who was appointed his successor by the President.

Changes at Emergency Hospital.—Dr. H. L. E. Johnson, executive officer of the Emergency Hospital, summarily dismissed Dr. D. T. Stewart, resident physician of that institution, on September 24th. The reason given was that Dr. Stewart had struck a patient for biting the physician's finger while being treated for attempted suicide. Dr. Stewart admitted the charge, but said he considered the circumstances justifiable.

Black List.—The physicians of Washington have inaugurated another effort to protect themselves from non-paying patients. Some years back a similar effort resulted in failure. The new association is known as "The Doctors' Protective League," and proposes to provide each member with a list of "bad pay patients," and also formulate a fee schedule.

THE HAHNEMANNIAN MONTHLY.

DECEMBER, 1902.

URINE ANALYSIS—A NEGLECTED DIAGNOSTIC MEASURE.

BY CHARLES PLATT, M.D., PH.D., PHILADELPHIA.

Professor of Chemistry and Toxicology, Hahnemann Medical College and Hospital,
Philadelphia.

MANY may incline to doubt the statement that urine analysis is the most neglected of diagnostic measures, but such I hold to be a fact, and I propose, in a general way, to explain in what manner this valuable aid has been disregarded. I know, of course, that every physician has somewhere in his office a urinometer and a bottle of nitric acid, but what can be learned with these is hardly worth the trouble of the test, and it is in the sense of the complete examination alone that my text applies, as it is, alone, the complete examination that is of value. From time to time the desire for a more exhaustive analysis than ordinary may arise, but how often then is it found that lack of familiarity with the tests involved renders the ambition of the physician impotent. Text-books must be consulted, and the directions there given followed more or less closely, much as a cook-book recipe might be followed; but neither text-book nor cook-book can supply that *savoir faire* born of experience, and so necessary to success. The result is, then, that the test is both faulty in execution and valueless in result,—as worthless, in its own way, as would be the gastronomic endeavor of the inexperienced *cuisinier*.

From inaccurate tests are derived false diagnoses, or where happily the physician possesses more judgment and less assur-

ance, the diagnoses become at least doubtful, and therefore of no assistance. With the physician who possesses the assurance rather than the judgment, and who confidently asserts his fallacious conclusions, the result may be indeed disastrous to the patient. The sequel of the error is invariably the condemnation of the analysis; and, the death of the patient having suggested that the doctor might be wrong, the latter blames the method, which he now asserts to be of no value, declaring that he is done with so untrustworthy a measure,—that he will have no more of it. From the moment of this decision the doctor's patients are in less danger than before; henceforward they will be deprived of the benefit of a valuable diagnostic measure, but they will be in less danger of false diagnoses and of the resulting false therapeia.

Possibly some unkind reader may find in the above the plea of a specialist to be allowed to do the work correctly, and such a misconception may be excusable (for what else are journal articles written?); but my contention is that the kind of analysis to be referred to need not be limited to the laboratory of the specialist. I contend that a proper analysis is possible to many if not most men who now neglect it; that it merely requires a chemical understanding and familiarity with the tests, and the exercise of a little gray matter in the linking together of the secreted and excreted facts, as we find them in the urine, with the processes of metabolism, of secretion and excretion, as we conceive these functions to exist within the body.

I have referred to the complete analysis. Of what should this consist? A knowledge of the amount of urine passed in twenty-four hours; an average specimen of this same; the appearance and other physical characteristics of this sample, with its density, etc., and the character of the sediment, if there be any. The determination of the reaction, the relative degree of acidity or the cause of alkalinity, as the case may be; the total amount of solids excreted in the twenty-four hours; the amount of urea in the same period; and the relative amounts of the chlorides, sulphates, phosphates, and indican. Qualitative and, if present, quantitative tests for albumin and sugar, with qualitative tests for acetone, diacetic acid, bile and blood. Exceptionally may be required the quantitative estimation of uric acid (and urates), the differentiation of the sulphates of

organic and inorganic bases, the differential determination of the earthy and alkaline phosphates and of the unoxidized phosphorus, tests for the diazo-reaction, for peptones, nucleo-albumins, and for bile salts.

The sediment, obtained by means of the centrifuge, should be examined microscopically for epithelium, for mucus, for leucocytes, for pus, for blood, for casts, for uric acid, and for urates, oxalates, and phosphates. When, as in the case of epithelium, casts, phosphates, etc., a variety of forms of each may be present, each form should be carefully noted, and the relative amount of each determined. More unusual sediments, such as cystin, leucin, carbonates, etc., should be confirmed by micro-chemical tests; spermatozoa and other occasional anatomical forms should always be noted.

To the doctor who is accustomed to tell his patient to "Bring a sample of your water next time you come," and then who examines the sample by placing it on a shelf in the bath-room, and who is able to inform the patient, as the result of this examination, that his system is full of uric acid, but that he (the doctor) will try to get it out, and that he will require a sample of water each week, etc. (this last on the same principle, I suppose, that the voodoo man requires a bunch of hair from his consultant's head, in order that his charms may be the more effective),—to such a doctor the detail of the complete analysis may appear burdensome. But even to the more worthy physician it will, of course, be evident that such an analysis can not be made in the study of every illness presenting, nor would this be always helpful. Every regular patient, however, should receive the benefit of such an analysis at intervals, say, of one or two years, and, more often, at intervals of two or three months, where there is any reason to suspect a disturbed metabolism or a deficient excretion. The study of a new patient, too, particularly when the latter consults for a chronic illness, should begin always with a complete urine analysis, while later, in many cases, isolated tests will suffice; in some cases, for instance, a test for indican will give the desired information; in others, the estimation of the chlorides, or, it may be, of the urea, and so on. Having by our first examination learned something of our patient's general condition, these special tests will often be sufficient for a considerable period.

A necessary preliminary to the complete examination, indeed the most important part of that examination, is the collection of the urine for twenty-four hours, the measure of its quantity, and the obtaining of an average sample of the whole. As well invest your money in a mining property (as some, indeed, incline to do) on the result of the analysis of a single piece of ore, as to endeavor to know anything of your patient's condition from an analysis of a single passing of urine. When the average sample cannot be obtained, the only tests of the slightest value are the qualitative tests for albumin and sugar, and the microscopic examination of the sediment.

The physical characteristics, the reaction, the specific gravity, the urea, the chlorides, phosphates, etc., should be disregarded absolutely. These tests would be more than worthless,—they would be misleading. For instance, the urine of the single passing may have a specific gravity as low as 1002, and yet the normal, 1020, may be obtained on the twenty-four hours' sample; urea may be as low as 0.5 per cent. or as high as 4.0 per cent. on a single passing and still be normal in the twenty-four hours. Even though we recognize this possibility, a low, or a high, or a normal figure will, however, still unconsciously warp our judgment and leave behind an impression which may be entirely erroneous; and therefore, I say, the test should be omitted.

It is not only to obtain the average sample that we save the entire twenty-four hours' excretion, for the knowledge gained of the quantity passed is of great value in arriving at a diagnosis. Particularly is this true in kidney diseases, as witness the decreased amount in acute diffuse and in subacute glomerular nephritis, and, on the other hand, the increased amount in chronic interstitial nephritis and in amyloid disease; compare the increased amount in chronic interstitial nephritis with the normal or decreased amount in the ordinary senile kidney which otherwise so resembles an interstitial nephritis both chemically and microscopically. In extra-renal diseases note the decreased amount, generally with increased color in fevers, or with decreased color in absence of fever; compare the increased amount in hysteria with the decreased amount so common in neurasthenia and in melancholia; note the decreased amount in valvular affections and the increased amount in di-

abetes mellitus and insipidus, and in the convalescence from acute diseases in general.

Comparing the quantity passed with the specific gravity, we get still more accurate data for our diagnosis. An increased specific gravity with a decreased amount of urine may be either physiologic or pathologic—it may represent loss of water by other excretions or it may be the urine of fever, of acute nephritis, or of the active stage of a subacute glomerular nephritis, etc. A decreased specific gravity with an increased amount, again may be either physiologic or pathologic—it may represent simply the ingestion of excessive fluid, the chilling of the body-surface, or it may represent the absorption of exudates, an interstitial nephritis, an amyloid kidney, a chronic diffuse nephritis with exudation, or a diabetes insipidus. It is evident that so long as the specific gravity and the amount of urine vary inversely with each other the condition need not be pathologic; but, on the other hand, when we find the specific gravity and the amount of urine varying in the same direction, both increasing or both decreasing, a high specific gravity with a large amount of urine or a low specific gravity with a small amount of urine, then we must surely have a pathologic condition present, and, I may add, the character of the condition will probably be suggested by a consideration of these simple physical factors alone.

In reality the specific gravity is determined as a measure of the total solids, the latter being commonly calculated by multiplying the last two figures of the specific gravity (water being 1000) by either Häser's, Loebisch's, or Trapp's coefficient, the first named, 2.33, being the most frequently used, and also the least accurate. We are not discussing methods, but let me suggest that, when the total solids are to be calculated therefrom, the specific gravity be properly taken, correcting for temperature (if the urinometer be registered for 60° F., ascertain the temperature of the urine and add 1 to the observed specific gravity for each 6° F. above 60°) and having the urinometer tube filled to the brim. It is probable that in most cases the observed specific gravity is from 2 to 4 points below the true specific gravity, an error which will become the more serious as the amount of urine increases. In a polyuria of 3000 c.c., the observed specific gravity being 1010, the calculated total solids

would be 69.9 grammes, while, were the specific gravity corrected to 1014, the calculated total solids would be 97.9 grammes, a difference of 28 grammes, or 432 grains,—a fair-sized error, considering that it represents an amount of solids equal to the total excretion of some patients.

It should be remembered, too, that the total solids may be calculated with clinical accuracy only when the urinary solids are fairly normal in their relative proportions, and that, should the urine contain a large amount of albumin, or, particularly, should it contain sugar, the total solids cannot be calculated from the specific gravity at all. Again, would it not be an improvement over our ordinary carelessness if, in deciding whether or not the total solids found were normal, *i.e.*, represented a normal degree of metabolism, we should inquire what normal to expect in our patient, taking, therefore, into consideration the patient's age, diet, physique, and general condition? The normal for an adult male is commonly stated at about 1000 grains. Suppose your patient passes 600 grains of solids, do not jump to the conclusion that his kidneys are deficient in excretory power, or that his metabolism is low, unless you have considered the conditions cited above. Suppose that your patient is a man of 60 years, confined to the house, and on a moderate diet, the normal excretion for such a one is about 540 grains, and the 600 grains passed, then, would indicate a perfectly normal function.

As regards the rest of the analysis, most physicians probably limit themselves to the tests for albumin and sugar, with an occasional examination of the sediment, or, in other words, use the analysis merely as an aid in the recognition of kidney disease and of diabetes mellitus. The urine, however, is a measure of the general metabolism, and should be regarded as a product of the cellular activity of the entire body, and not as a renal fluid alone. The kidneys play a part in its formation, it is true,—both a secretory and an excretory part; but in the larger sense the kidney is merely an incident in the path of excretion. Were a sample of water to be drawn from a house faucet and analyzed, it would be to learn something of the source of the water, the condition of the watershed whence it had come. Such an analysis would not be limited to the investigation of the local plumbing. So in urine analyses we

should endeavor to learn something of the general condition of the patient, and should not limit ourselves to the investigation of the local excretory apparatus. *A complete urine analysis, properly made, is of as great importance in the study of extra-renal diseases as it is in the study of diseases of the urinary tract,* and it is here, though not here alone, that the details of urinary composition become particularly significant. From this point of view, the total solids become a measure of general metabolism; the reaction, an index of the stomach and blood; the urea, a measure of nitrogenous metabolism, and, with the uric acid, an approximate gauge of the body-poisons, the leucomaines, etc.; the chlorides tell of exudates and of absorption, of the fever crisis, etc.; the sulphates, of proteid metabolism and of intestinal absorption; the phosphates, of brain and stomach; the albumin, of the heart and lungs, of the arteries, and of pelvic pressure; sugar, of the pancreas and brain, of the suprarenals or liver; indican, of suppuration, of lesions of the small intestine; diacetic acid, of abnormal or diverted katabolism, etc. These factors become of value now, too, in differential diagnoses, whether of renal or extra-renal disorders. Compare typhoid with cerebro-spinal meningitis: in both the urine is decreased, the specific gravity is slightly increased, the urea is increased, and albumin is often present; but in meningitis the tendency is toward a pale urine, in typhoid the urine is generally dark; in meningitis the chlorides are greatly decreased, in typhoid only slightly decreased; in meningitis the phosphates are increased, in typhoid they are decreased; in meningitis the acidity of the urine is lessened, in typhoid it is increased; in meningitis the diazo-reaction is rare (1 per cent.), in typhoid it is the rule (96 per cent.).

Compare acute miliary tuberculosis with typhoid: in the former the solids are decreased, in typhoid they are generally increased; in acute general tuberculosis the urea is generally low, in typhoid it is generally increased; in tuberculosis the phosphates are increased, in typhoid they are decreased; in tuberculosis the diazo-reaction is obtained late, if at all; in typhoid it is early, and seldom absent. Compare hepatogenous icterus with hematogenous icterus: in both, bile-pigments are present; but, as regards the bile-salts, the glycocholate and taurocholate of sodium, these are found only in the hepatic

form of the disease. Consider the value of indican in locating intestinal lesions; note the suggestive neutral urine with decreased chlorides in gastric ulcer (hyperchlorhydria), and the acid urine with normal or increased chlorides in gastric cancer; note the increase of phosphorus and of uric acid in splenomedullary leukæmia and the absence of this increase in the lymphatic form (unless, indeed, potassium bicarbonate form part of the treatment in the latter condition); and so we might proceed through all the long list of ills to which the body is heir.

The urine truly, then, is something more than a kidney product, and its analysis has other uses than an investigation of the kidney condition. Possibly the examples chosen at hap-hazard above are not well selected to prove my point, but still it must be evident that, from a careful analysis, much information may be obtained and many a difficult diagnosis decided. Moreover, I may add, the interest of the analysis does not end with diagnosis; it will give us the information necessary for our prognosis, and it will put us on our guard against impending dangers. In threatened eclampsia, for instance, we are warned by our complete analysis (not by the ordinary senseless test for albumin), we are given an opportunity to anticipate by the institution of prophylactic treatment, or, should our prophylaxis fail, we are at least placed in readiness to meet the attack when it arrives.

In obstetrical practice, in general surgery, and in ophthalmic practice, as well as in general medicine, the urine remains a most instructive fluid. Does the average physician appreciate its value? I think not, and I repeat that urine analysis to-day is the most neglected of diagnostic measures. Let those who are inclined to cavil at the statement study the subject honestly, and no further argument will be required to convince them of their error.

THE EFFECT OF HYPERTROPHIED TONSILS UPON THE GENERAL HEALTH.

BY H. S. WEAVER, M.D., PHILADELPHIA.

(Read before the Pennsylvania State Homœopathic Medical Society.)

ENTIRELY too little attention has been directed toward the tonsils, which, when hypertrophied, are so productive of other injurious effects upon the general health, especially in children, that I thought a paper setting forth some of the diseased conditions resulting from overlooked or neglected tonsillar abnormalities might be of interest to the society.

A great diversity of opinion exists among physicians as to what constitutes a pathological hypertrophy of the faucial tonsils which renders them capable of producing disease, and a menace to the normal, mental and physical growth of children.

Just how large the tonsil may become before it should be classed as a diseased one and not competent to perform its physiological functions is a much disputed question. Some claim that when a tonsil protrudes beyond the edges of the anterior and posterior palatal arches it is pathological and requires treatment. Others contend that nothing should be done with them unless they project far into the fauces and interfere with speech, deglutition or respiration; while others insist that the tonsils should be left severely alone, claiming that their removal will cause impairment of speech, sterility, and probably insanity.

My experience has taught me that the first of these statements is more nearly correct; that tonsils which protrude to any extent beyond the edges of the pillars are abnormally hypertrophied, and must of necessity make pressure on some of the surrounding parts, causing more or less congestion and inflammation of the fauces, with a concomitant hypersecretion of mucus.

The faucial tonsils, two in number, are situated one on each side of the fauces, between the anterior and posterior folds or pillars of the soft palate, and when normal have a more or less

smooth surface which does not protrude beyond the edges of the pillars; and are approximately the size of a small chestnut; while the abnormal are irregular in shape, and are frequently of sufficient size to completely fill the faucial space, rendering a view of the pharyngeal wall impossible.

When the lower lobes are enlarged the symptoms are more marked; breathing becomes labored, and the tone of voice is completely changed, becoming mushy or throaty in character, differing from that found in adenoid obstruction, which is characteristically nasal. Associated with these lower hypertrophies, there are in a few cases enlargements at the base of the tongue, interfering to some extent with deglutition. The palatal and pharyngeal muscles in many of the marked cases are not well developed because of the muscular inactivity due to the overcrowding of these parts by these enlarged masses. Owing to the sluggish action of the muscles and the stringy character of the mucus, it is very difficult and in many cases impossible to clear the throat of this hypersecretion, and it finds its way into the œsophagus, larynx, and at times into the bronchial tubes.

Enlargement of the tonsils may be classified into three varieties,—interstitial, lymphoid and lacunar,—and is the result of repeated acute or subacute inflammation of the gland, or is a congenital enlargement, or it may be a possible local manifestation of some constitutional diathesis.

In the interstitial variety there is an increase in the fibrous or connecting structures which separate the lacunæ and form the body of the gland itself. This increase of the interstitial substance is usually the outcome of frequent attacks of either acute suppurative or non-suppurative inflammations, and when examined under the microscope show a rich blood-supply with numerous dilated capillaries, and in the deeper structures dilated blood-vessels.

The lymphoid hypertrophies are those usually found in very young children, and are simply enlargements of the normal structures of the gland; but as time progresses and the inflammations continue, it gradually loses this characteristic and resembles more closely the interstitial variety.

In the lacunar variety the tonsils are filled with numerous small openings called crypts, lacunæ or follicles, which pene-

trate the gland and frequently subdivide it into smaller pockets, so that a probe may be passed into one opening on the surface, and, as it enters the deeper structures, communicate laterally with a number of other pockets. These, from their macroscopic appearance, are called "honeycombed tonsils," and are those which cause most of the diseased conditions referable to hypertrophied tonsils.

The crypts are lined with epithelial cells which in many cases are in a state of chronic inflammation, indicated by a distinct thickening of the epithelial layers and accumulation of broken-down cells, partially or completely occluding the orifices of the ducts. In many instances the broken-down cells, tonsillar secretions and pus contained in these pockets are forced out by the muscular action required in speaking, masticating, and during deglutition, so that they are kept comparatively clean and free from additional inflammation, while in others the openings are so small that the secretions block the outlets and prevent escape. When this occurs the retained materials undergo degeneration, causing more inflammation of the lining membrane, and later extend into the parenchyma of the gland, and, by the addition of some exciting cause, develop one of the acute tonsillar diseases. By making pressure on these honeycombed tonsils, large masses of caseous and occasionally calcareous deposits may be squeezed out of these crypts, and, if examined under the microscope, show abundant bacteria, chiefly streptococci and staphylococci, with some pneumococci. From the congestion and inflammation of the fauces there is more or less inflammatory exudate present, consequently there is not infrequently a fibrous union between the tonsils and the free edges of the pillars; this union forms a deep pocket into which small particles of food, mucus and tonsillar secretions find their way; and as the only outlet is above, and the depth varies from one to one and a half inches, the pocket usually contains quantities of offensive matter which leads to acute tonsillar and peritonsillar diseases, such as acute erythematous tonsillitis, which involves only the superficial structures; parenchymatous, involving the whole gland, which in many cases results from pent-up secretions plus a debilitated constitution; acute follicular, involving the follicles; this being the one to which I wish to call special attention because of its frequency among those suffering from tonsillar hypertrophies.

As regards the general health in these conditions, it must be remembered that in the great majority of cases there is associated with these faucial tonsillar enlargements more or less involvement of the pharyngeal or Luschka's tonsil, commonly called adenoid growths, and only differing from the former in being softer and more friable. Separately or together, their effect upon the health is to reduce it far below the normal standard.

It is the exception rather than the rule to see bright, active, healthy, robust children with these enlargements, and the statement has been made by some very eminent observers that in many cases suffering from tubercular adenitis, the infection has occurred through the tonsils. The tubercle bacillus gains entrance through the crypts to the lymphatic circulation, and through these channels infects the whole chain of cervical glands. These patients are usually pale and anæmic, thin, ill-nourished, hollow-chested, nervous individuals, with expressionless faces, sunken eyes, open mouths, and frequently have a semi-idiotic expression, presenting all the signs of having dulled or undeveloped intellects. They do not progress satisfactorily at school, are slow in grasping new ideas, and not infrequently are accused by the teacher of being inattentive or dull of comprehension; but when the true condition is ascertained, all these failings result from the child's inability to hear distinctly. They are not able to join in the more violent sports because of the lack of physical endurance.

From the lowered resisting power, and the lack of recuperative power after each illness, they are rendered more liable to contract fresh or additional cold from each change in the weather, or slight exposure, not noticeable to healthy individuals.

Coughs resulting from chronic bronchial or faucial congestion, especially during cold weather, are their constant companions, and remedies even when very carefully selected are only palliative, because the exciting cause has not been removed. There is frequently defective hearing resulting from the pressure upon the Eustachian tubes by the enlarged tonsils, and from the improper aëration of the middle ear arises the concomitant ear symptoms. Otagia is present, and at times, owing to the extension of the inflammation from the fauces

and naso-pharynx through the Eustachian tubes to the tympanic cavity, there develops an acute otitis media.

The more I examine into the cases of chronic catarrhal deafness and tinnitus as found in adults, the more I am convinced that many of them could have been prevented had the tonsils and post-nasal adenoids been removed during childhood. Usually, in these cases, there is a catarrhal discharge from the throat stringy in character, and, from the muscular inactivity of the parts, it is almost impossible to loosen and expectorate the mucus; consequently, quantities of it are swallowed, and the result is some impairment of the digestive tract. As a rule the appetite is poor, and sweets instead of good substantial foods are craved; but in some cases where the patient eats ravenously the food does not nourish, and he remains thin, pale, and anæmic.

The treatment may be divided into remedial and operative, —the former including the internal administration of proven drugs, selected for the specific action on these glands, and the local application of various absorptive and astringent agents directly to the enlarged tonsils. By the operative treatment the gland is either partially or completely removed. The line of demarcation between tonsils requiring surgical interference and those which can be removed by internal treatment is not sharply drawn, and differs in each individual, owing to the severity of the symptoms. Some tonsils, not large enough to cause pressure or appreciable interference in the fauces, are so diseased that their removal is imperative, while others much larger are so nearly normal in character and function that their removal is not a necessity. Burnett, in his work on the treatment of hypertrophied tonsils, claims that all cases can be successfully cured without operation by the selection of the proper internal remedy. I have prescribed to the best of my ability, both in private and hospital work, according to his given indications and the totality of the symptoms, but have not had the same flattering results. True, many of the symptoms have subsided, and the patient has for varying periods of time remained well; but in nearly every case, with the slightest exciting cause, there is a renewal of the old tonsillar troubles, proving that the underlying diathesis has not been removed. Soft and moderately enlarged tonsils, under homœopathic

treatment plus local applications, are frequently relieved of the symptoms, but rarely is there a marked decrease in the size of the gland itself. It is true the tonsils undergo atrophy later in life, and for this reason many physicians object to their removal; but long before this anticipated atrophy begins, conditions and symptoms develop which resist all treatment and handicap the individual through life.

In the lacunar hypertrophy very beneficial results may be obtained by tearing up the partitions, separating the different pockets, and making one large one from a number of smaller ones. This may be repeated at intervals of a week, and in a very short time the tonsil will shrink to half its former size. The galvano-cautery knife is a very effective means of reducing the glands, but is not applicable in children. Its field of usefulness is chiefly in adults, where the tonsillitome is contra-indicated, either by age or a "bleeding" history. Again, when patients absolutely refuse operative work, electricity may be advised, and in nine out of ten cases will be accepted. This method, while slower and more painful to the patient, will accomplish much the same results if persisted in for a sufficient length of time.

My experience has been that the best results are obtained by the removal of all that portion of the gland which protrudes beyond the edges of the soft palate by a tonsillitome. This can be done under a local anæsthetic, except in young children; and, where there are post-nasal adenoids, then a general anæsthetic is preferable.

I have never seen any bad effects follow the removal of the diseased portions of the tonsils, but, on the contrary, I have been delighted, after the lapse of a few months, to see the wonderful change for the better. The clear and resonant voice, the easy respiration, the absence of the pronounced nervous symptoms and the brightened intellects, all give testimony to the beneficial effect of operation.

SECONDARY DEGENERATIONS FOLLOWING SPINAL FRACTURES.

BY JOHN J. TULLER, M.D., PHILADELPHIA.

IN reviewing English, French and German literature on the subject of secondary degenerations following fractures of the spinal column, we find that as far back as 1866 scarcely anything had been written. While much has appeared on the subject of spinal fractures, and on ascending and descending degenerations, we find comparatively little in which the two have been considered together. And this seems strange, in view of the fact that the prognosis of spinal fracture is invariably grave, and that the secondary degenerations taking place as a result of injuries to the cord from fractures of the vertebræ give us the cleanest-cut definition of the spinal pathways that it is possible for us to find.

It is important from the standpoint of prognosis, because invariably the first question asked, when a paralysis occurs as a result of a fracture of the vertical column, will be, "Will the patient recover from the paralysis?" and, second, "If not, how long will he live?" Naturally, we find the prognosis is good or bad in proportion to the amount of injury done to the cord, and, again, as regards location of the injury.

We have, in literature, many cases described as fractures of the vertebral column, as dislocations of the vertebræ resulting in serious injury to the cord, apparently, which recover. We have flaring out in the most spectacular form, in the journals of the present day, announcements of broken backs and broken necks, with marvelous recoveries.

One of the benefits to the general practitioner from a paper of this character, particularly those who have little knowledge of what an injury to the spinal cord means, is to place him upon an intelligent basis to discuss such articles with his patients who may be inquisitive enough to question him on this subject.

Permit me to make this statement: that where serious injury, or even where comparatively slight contusions, with infiltration of minute extravasations of blood over one or more

segments of the spinal cord, destroying the fibres and the cells, exist, repair is out of the question. I firmly believe that the so-called cases of destruction, to a more or less degree, of the spinal cord, resulting from fracture or dislocation, are nothing more than spinal shocks, or shock to the nerve-cells of the spinal cord, where recovery takes place. For, once realizing the character and the component parts of a spinal fibre or a spinal nerve-cell, understanding its mode of nutrition and contiguous structures, one can readily understand how not only the interruption of nutrition, but the injury to the envelopes, results in permanent destruction of the function of that individual fibre or cell. More than this, once the fibre has been injured to the degree of destruction at a given point, death must follow in the continuous course of that fibre to its termination in the direction of its impulse.

Degenerative changes taking place in nerve-fibres advance in the direction which the normal nerve-impulse takes. For instance, the normal motor-impulse is downward and outward from the point of its origin; a sensory impulse is inward and upward from the periphery to its point of termination in the central nervous system. While this is not altogether invariably true in regard to all nerve-fibres, it can be taken in general as true as far as the demonstration of the pathways from secondary degeneration of the spinal cord is concerned for our present purpose.

Once we have a destruction of a fibre passing to a certain cell, from which this cell receives its stimulus, a suspension of the function of the cell follows, and a consequent atrophy. It is possible, after an injury at a given point in the spinal cord, to block out perfectly the motor pathways below and the sensory pathways above, so far as the fibres pass continuously from the point of injury up or down. In the specimens which have been prepared from the cases that are to be cited, we can prove absolutely that the column of Goll, for instance, lying, as it does, in the posterior median portion of the cord, gathers its fibers from the exceeding end of the cord, and transmits them to the nucleus of Goll in the medulla in a single direct line. We find, further, that the column of Burdach, lying in the posterior lateral portion of the cord, does not transmit its fibres continuously from the extremity of the cord, but constantly

gathers them all the way up to the nucleus of Burdach in the medulla.

Microscopic examination, after a complete severance of the cord in the lumbar region, shows that the column of Goll becomes ultimately degenerated through its entire course, while the column of Burdach is degenerated but a short distance above the point of injury, and that, as the new fibres gathered on its way to the medulla enter the cord, they do not partake of the degenerative process that has attacked the column of Burdach in close proximity to the injury. As the column of Goll ascends, the degenerative process gradually narrows down, until, by the time it reaches the cervical region, it has become a comparatively small, narrow space of degenerated fibres. This proves to us that a certain portion only of the fibres of the column of Goll traverse its entire pathway, and that, as the fibers from the column of Burdach enter the cord at a given point above the injury, they press their way over into the column of Goll, and form part of this pathway.

That certain of the fibers of the column of Burdach pass into the gray matter of the spinal cord is evidenced by the fact that a short distance above the point of injury these degenerated fibres disappear. It is therefore possible to trace the sensory fibres arising free from the lower segments of the spinal cord to what is known as the nucleus of Goll, lying in the lower segment of the medulla, through the column of Goll, but no further, as far as our present means have been developed. Certain it is that the spinal fibres traversing the pathway known as the column of Goll terminate in the nucleus of Goll, and from this point the sensory pathway has a new birth.

We are able in certain of our specimens, where the injury has been sufficient to attack the antero-lateral portion of the cord, to outline in the greater part of the entire length of the cord the columns of Gower by the degenerative changes. We are able to trace, as well, in the sensory portion of the cord above the point of injury, the cerebellar tract to the medulla; and, peculiar as it may seem, these tracts become positively and absolutely outlined. At the immediate point of injury all tracts undergo degeneration, because there is a complete transverse inflammation of the cord, due to traumatism; but as we

pass upward, drawing further and further away from the injury, we find that only the ascending sensory structures undergo degeneration. As the new fibres enter the cord the degenerated fibres disappear in the gray matter.

Below the point of injury we find, first, the blocking out of the crossed pyramidal tracts. These tracts are composed of the motor fibres which have their point of decussation in the medulla, being located in the lateral portion of the cord. Second, the direct cerebral tract occupying the anterior portion of the white matter located between the anterior horn and the anterior fissure. It is peculiar to both these tracts that to the extent of the cord below the injury they undergo degeneration, showing absolutely that both the pyramidal and the cerebral tracts are continuous to their point of exit. In the fundamental lateral and antero-lateral tracts, the degenerative process occupies but a comparatively short space above and below the injury, and at a given point both above and below, the tissues constituting these tracts present normal fibres. This shows us that these fibres are in reality fibres connecting the different cell-structures of the spinal cord at different localities, and do not at any time continue their course either to the termination of the cord or as far up as the medulla.

In the gray matter, which is composed of the cellular structure of the spinal cord immediately about the injury, complete destruction of the cells, and of the fibres traversing the gray matter which arise from and are distributed to the different cells, takes place. The anterior multipolar cells become degenerated, atrophied, and subsequently destroyed. The cell-structures in the posterior horns, and in the median gray matter as well, partake of this degeneration. As we pass from the injury to a given point below, the anterior multipolar cells occupying the anterior horns become atrophied, and the peri-cellular spaces contain small, shrivelled, atrophied cells. This same degenerative change takes place to a certain degree, and the cell-structure from a given point above the injury in both the posterior horn and the columns of Clarke. This would lead us to believe that the columns of Clarke, as well as the posterior horns, are made up of cells which have an afferent function. We find that the cell-structures occupying the commissural lateral gray matter, the so-called median zone, except for a certain space about the

injury, undergo but little alteration. This, again, would lead us to believe that these cells have an individual function dependent upon a stimulation arising within themselves, and dependent only upon their blood supply for their activity.

As regards the cell-structures, which are of such great import in the spinal cord, immediately surrounding the central canal, we find scarcely any change except, perhaps, as the result of pressure from a slight dilatation of the canal after we pass beyond the point where the structures are directly involved from the injury.

It should be remembered that all degeneration of the fibres of the spinal cord, whether ascending, sensory, or descending, motor, undergo the same character of change, namely, atrophy, destruction of the medullary sheath, an ultimate destruction of the axis cylinder, at first a collapse, and finally a thickening of the neuralema. As to the structure above a given point in the medulla, there is evidently no change, for in no case where the injury is below the medulla is there present either atrophy or destruction of sensation in any portion of the head or the upper part of the neck.

In cases which we will cite, we will find that two of the patients came to the termination in exactly the same way, namely, a development of syncope; first tachycardia, then slowing of the heart, associated with extremely shallow respiration; then a gradual passing of the attack, and a recovery to normal. Day by day these spells grew more frequent and more persistent, until finally, after a period of from eight to ten days, in one of them the mechanism ceased. This, we have reason to believe, is an action upon the pneumogastric centre, and may or may not be the result of the ascending degeneration attacking the sensory centre of the pneumogastric nerve. Further proof of this fact is found in the symptoms exhibited by one of the cases cited immediately after the injury, which were the exact counterpart of the symptoms that brought about the final termination, and we are led to explain these symptoms on the ground that the injury, occurring at a point corresponding to the third cervical vertebra, produced an inflammatory process acute in character, which caused a pressure on the pneumogastric centre located at the lowest portion of the medulla.

In view of these facts, and considering the character of de-

generation, considering, as well, the immediate effects on the spinal marrow of a vertebral fracture that in any way involves the structural portion of the cord, is it possible for complete recovery to take place? and can we not say that, where the cord itself has been involved, the prognosis must be at least extremely grave, if not invariably fatal?

As a means of illustrating the above, I desire to cite three cases.

CASE I.—P., a policeman, 53 years of age, brought into the Hahnemann Hospital on — day of —, with an injury to the eighth and ninth dorsal vertebræ, with complete paralysis both of sensation and of motion from the waist down. Laminectomy was performed, and the cord was found to be partially severed at the level of the ninth dorsal vertebra, small spicules of bone being driven into the substance of the cord. These were removed, the wound dressed, and the patient put to bed, suffering but little shock, and recovering from the effects of the operation without any unusual developments.

Marked atrophy followed in a few days, a result of the injury, distributed generally through the muscular structure of the body from the waist down. The urine and stools were involuntary. Beyond this, no especial change took place in the patient during a course of six months. About ten days previous to death the patient developed attacks of syncope, associated with tachycardia, which gradually developed into almost complete cessation of the heart action, associated with shallow respiration and decided pallor of the face, then gradual return to the usual condition. These spells grew more frequent during a period of about ten days, and the patient sank lower and lower in vitality, and finally passed away in one of them.

The post-mortem examination showed an injury to the cord, severing it in about two-thirds its posterior portion, with some infiltration of calcareous salt about the wound, decided adhesions of the membranes, and an ingrowth of bone into the substance of the cord. The bodies of the vertebræ had not been injured. The arches and the spines of the eighth and ninth dorsal had evidently been crushed at the time of injury, and had been removed at the operation. Outside of the fact that there was some slight atrophy of the cord in general, nothing macroscopically could be discerned beyond what has been described.

The microscope showed complete destruction of the posterior and lateral portions of the cord for a short distance above and below the point of injury, with a preservation of the anterior portions of the cord with comparatively little degenerative process. At a given point below the injury the cross pyramidal tracts had undergone such a degree of degeneration that they

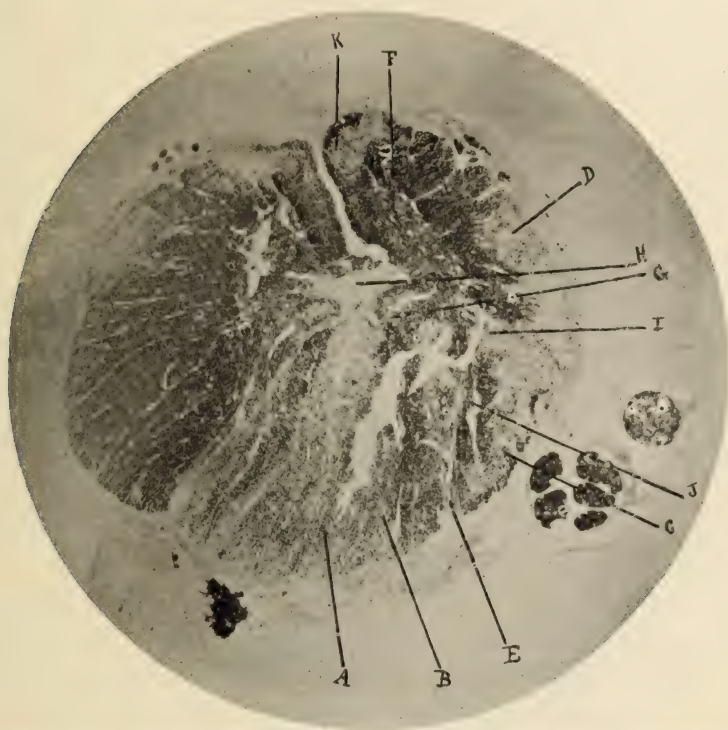


PLATE 1.—Section through the spinal cord just above the break, showing the general inflammation and distortion. Stained after Pal's method. The spots on the margin of the cord are bundles of nerve-fibres. A. Columns of Goll; B. Columns of Burdach; C. Cerebellar tract; D. Gower's column; E. Posterior horn; F. Anterior horn; G. Columns of Clarke; H. Central canal; I. Ground bundle; J. Crossed pyramidal tract; K. Anterior column.

could not have been more perfectly blocked out had they been a steel engraving. The direct cerebral tract was not in any way involved, with the exception of a slight degeneration in the left segment of the cord, due to the fact that the anterior portion of the cord had been but little involved in the traumatism. Many cells of the anterior horn had undergone degeneration and

atrophy. At a given point above the injury, where the degenerative process arising from the injury had disappeared, we found complete degeneration of the columns of Goll, the columns of Burdach, the cerebellar tracts, and a partial degeneration of the columns of Gower. The fundamental lateral and antero-lateral tracts were unaffected a short distance above the injury. As we rose into the upper dorsal region the degenerative condition occurring in the column of Burdach entirely disappeared, and the degeneration occurring in the columns of Goll contracted more and more as we reached the cervical region, until, at a point just below the medulla, it occupied a small triangular space, the most posterior median segment of the cord, showing absolutely that these fibres had been transmitted to the medulla from the very conus. Further examination showed that these fibres entered the nucleus of Goll, and there the ascending degeneration disappeared. In the cerebellar tract we were able to trace the degeneration to the restiform body. The slight degeneration in the column of Gower passed from the point of injury to the medulla. The cells of the posterior horn above the injury had undergone atrophy to a certain extent, and some of them complete destruction. Certain cells of the column of Clarke were found to be destroyed; the fibres that normally traversed the gray substance of the posterior horn had undergone a degeneration.

CASE II.—L., 27 years old, entered the Hahnemann Hospital on the — day of —. Leaving his place of employment one morning, he sat down on a portion of a lumber pile; a plank fell over and struck him on the lower portion of the dorsal region. Laminectomy was performed four hours after admission to the hospital. It was found that the eleventh and twelfth dorsal vertebræ were injured; bodies not affected, but the arches and spines were broken. The removal of these exposed the cord about two inches in length; it apparently lay perfectly normal in its bed in the vertebral canal. The rotundity of the cord was preserved, and the membranes not ruptured. The patient recovered from ether with but little shock. The paralysis, however, was complete both as to sensation and motion from a point below the waist-line down; the bladder and rectum both involuntary.

The case ran the usual course, until the expiration of the

fifth month, without any apparent improvement in the paralytic condition. Towards the latter part of his sickness he developed a cystitis; after a short time this was followed by evidence of kidney involvement, which soon developed into toxæmia, and the patient died in convulsions.

The post-mortem examination showed fracture of the arches of the eleventh and twelfth dorsal vertebrae, infiltration of cal-



PLATE 2.—Section in the lumbar region below the break, showing the degeneration of the crossed pyramidal tracts and the anterior columns (slight). A. Anterior column; B. Crossed pyramidal tract; E. Posterior horn; F. Anterior horn.

careous salts into the very substance of the cord itself, while the cord showed no evidence of injury at the time of the accident. The membranes were adherent and stiffened by calcareous deposits; in fact, the body of the cord had become attached and apparently almost continuous with the bodies of the vertebrae at the point of injury, and from this point downward the spinal marrow had become so hardened with the calcareous

deposit that it was impossible to make microscopic sections of the lower segment of the cord. In spite of the fact that this cord was apparently uninjured at the time of the accident, it underwent a remarkable degeneration during the time that the patient lived after the traumatism. The secondary degenerations microscopically give us but little information that was not obtained in the above-cited case.

CASE III.—M., 17 years and 6 months, dived from a pier on Bailey's Island, off the coast of Maine, five feet above the water, in water that was four feet deep. Striking upon his head, he realized that some accident had taken place, for his body immediately became limp and rested upon the bottom. When he recognized the fact, by the bounding movement of his body on the sand, that some grave accident had occurred, he restricted his breath, and immediately rose to the surface. A fellow-bather carried him ashore and laid him on the sand. It was then discovered that he was paralyzed from the shoulders down. He was taken on the following day to the Maine General Hospital, in Portland, and operated by Dr. John Thompson.

The operation proved, apparently, that the arches and spines of the third, fourth and fifth cervical vertebræ were injured, and that the body of the fourth was partially crushed, as well as the cord lying over it. The young man recovered with but little shock from the operation. A prognosis of probably forty-eight hours was given.

In the meantime he developed attacks of syncope, associated with tachycardia, and finally almost cessation of the heart's action and shallow respiration. These were the attacks that were mentioned above as probably due to the extension of the inflammation resulting from the traumatism upward in the cord, with consequent irritation of the pneumogastric centre. This case made absolutely no recovery from the paralytic condition.

Shortly after the injury there were evident vasomotor changes demonstrated by the remarkable dropsical condition that developed. The kidneys showed, during the early stages of his sickness, evidence only of acute irritation, resulting from the enormous amount of *débris* which they were compelled to carry off, due to the atrophic changes going on generally through

the body. Finally the dropsical condition cleared away; the atrophic condition of the muscles over the body from the shoulders down became gradually complete; peculiar, changeable moods occurred in the early part of the illness, due undoubtedly to the hopeless condition of the patient; finally these subsided, and the patient employed himself by directing photographic reproductions. At no time during his illness

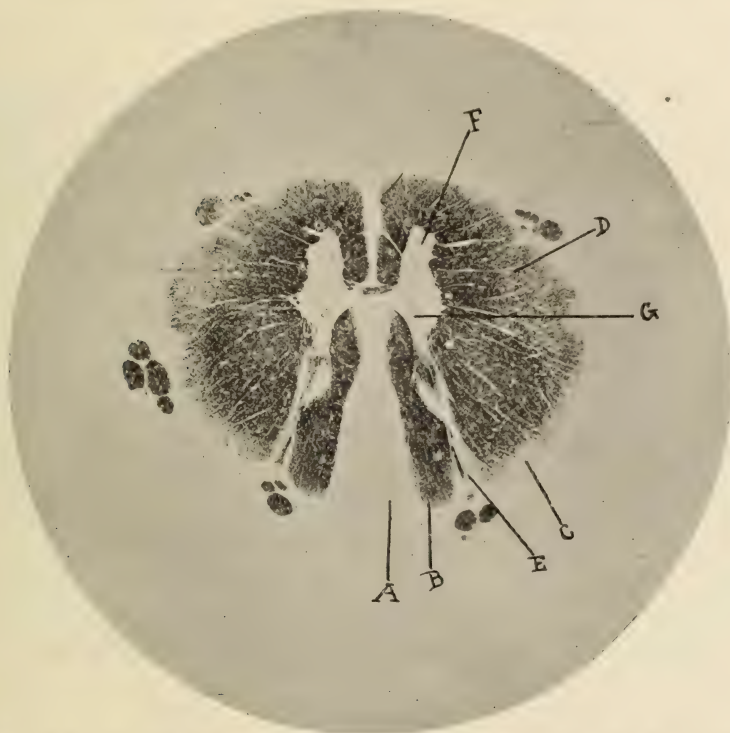


PLATE 3.—Section in dorsal region above the break, showing the degeneration of the sensory tracts. A. Columns of Goll; B. Column of Burdach; C. Cerebellar tract; D. Column of Gower; E. Posterior horn; F. Anterior horn; G. Column of Clarke.

were the visceral functions interfered with. After seventeen months in this condition the patient passed away, developing the gradual increasing attacks of syncope which had been manifested immediately after the injury, and which had ceased when the acute inflammatory process had subsided, and not again appearing until a few days previous to his death.

The post-mortem examination showed, first, in the spinal

column a partial crushing of the fourth cervical vertebra, a complete destruction of the arches and the spines of the third, fourth and fifth cervical vertebræ, and an evident severing of the spinal cord by crushing, at the time of injury, over the body of the fourth vertebra. The membranes, said not to have been ruptured at the time of injury, had become positively incorporated with what appeared to be a bone-formation filling the vertebral canal. The structure of the cord had become infiltrated with a bony deposit for a distance of about an inch, and

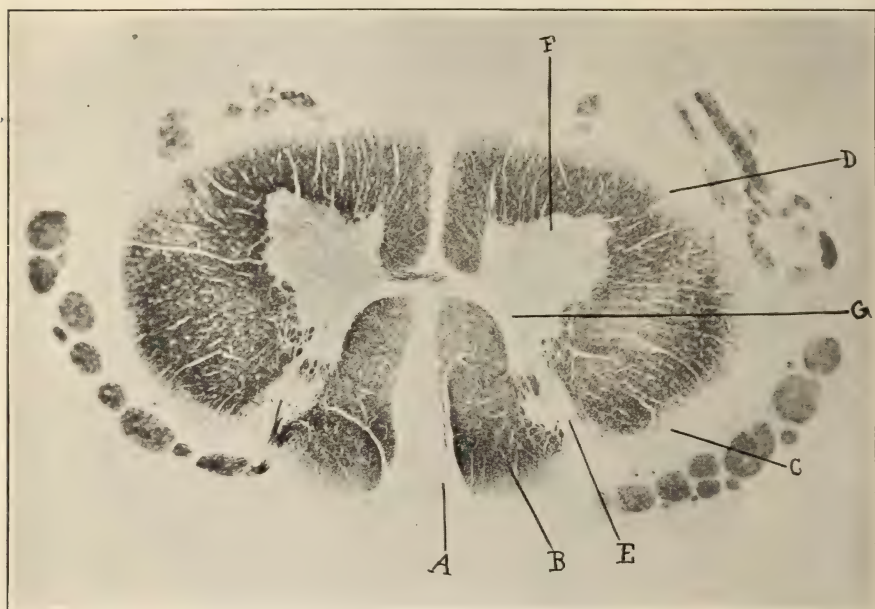


PLATE 1.—Section through the cervical region, showing the sensory degeneration. A. Column of Goll; B. Column of Burdach; C. Cerebellar tract; D. Column of Gower; E. Posterior horn; F. Anterior horn; G. Column of Clarke.

this was adherent and firmly attached to the new bone-process springing out from the body of the fourth vertebra. So firmly was this *débris* attached that it was virtually impossible to separate it from the bone-structure without serious mangling.

And now comes a most interesting part. This case that had been so carefully watched, that it had been anticipated would develop so much in the descending degenerative changes on account of the complete severance of the cord in the cervical region, and, again, on account of the fact that the patient had

lived for seventeen months after the injury, was absolutely destroyed to science by the ignorance and the bungling of the post-mortem. Without the slightest knowledge of the scientific value of this cord, the attending physician, in spite of the fact that every opportunity was offered to remove this specimen in a perfect state, persisted, by virtue of priority as attendant upon the case, in performing the post-mortem in the absence of those who knew, which resulted in the removal of the three vertebrae in question, with scarcely a remnant of the cord above and below the injury, except that immediately involved. As a result, we are compelled to refer only to the very imperfect degenerations which followed this injury, due to the immediate inflammation of the entire structure. No true description outside of the general outline of the pathways that has been given in the above cases can be demonstrated in this case, owing to the fact that the inflammatory process was so general that it destroyed the tissues irrespective of the nerve-tracts. A remarkable fact exists, however: that with all this injury to the spinal cord, so closely allied to the vital points in the medulla, and the remarkable storm that this body went through during the period of its illness, the general organs of the body showed absolutely no organic change, only a general anæmia existing.

The question now arises, in view of all these facts, Is the operation for the relief of these cases advisable? In post-mortem examinations we always know whether it was or not: but, since we cannot make the post-mortem examination before we do the operation, we come to a point in which we must decide as to the advantages and the disadvantages of operative procedure. While, from the neurological standpoint, I believe that operations are rarely beneficial, I am of the opinion that where the symptoms point to a fracture of the spinal column, grave or otherwise, operative procedure is the only treatment, for the reason that to-day the technique is such that, if the cord has not been injured, no harm is done, while, if injury has occurred in the slightest degree, our only hope of the restoration of the functions of the cord rests in operation.

HOMŒOPATHY: ITS RATIONAL PLACE IN DRUG THERAPEUTICS.

BY ALFRED WANSTALL, M.D., BALTIMORE, MD.

(Read before the Maryland Homœopathic State Medical Society, October 21, 1902.)

[BEING part of the opening discussion in answer to the question (submitted by Eldridge C. Price, M.D., Chairman of the Bureau of Materia Medica): "Assuming all knowledge of drug effects to be obliterated, how should we proceed to acquire reliable, practical knowledge of how to use drugs in disease?"]

The chairman of this bureau informed me that his purpose in submitting this question is to open a discussion which might bring out some views as to what better method might be adopted than the one now in practical operation. The question itself, and its purpose, would seem to infer that there are other untrod methods, theoretical or actual, which might be utilized to study how to use drugs in disease, and naturally gives rise to the counter-question: What are they? Besides pure empiricism, which is probably always based on some pre-existing pathogenic or therapeutic knowledge, and the study of the physiologic action of drugs on human and other animals, there only remain the effects of poisonings and provings by drugs on man, which are directly utilizable only by virtue of the principles of similars and contraries, and indirectly or remotely by empiricism, so far as I know; and inasmuch as the question and its purpose, owing to their purely theoretical character, are not further discussable, there remain for me to consider only the conditions which give rise to them.

That the results of the present method do not satisfy the profession is evinced by this question, and the reason why they do not, is not difficult to find. They fail to satisfy both the theoretical and practical requirements of the theory upon which the method is based. As there seems to be little reason to assume that the results of the present method of proving drugs are not in keeping with the natural difficulties inherent in that part of the subject itself, may not the trouble lie, not in the method and its results, but in an interpretation of the theory

not warranted by facts? and is it not probable that a rational interpretation of the theory, in the light of present-day knowledge, will show that the method and its results are all that we have any legitimate right to expect them to be? It is this aspect of the question that I propose to discuss as fully as possible in the very little, and wholly inadequate, time at my disposal. If what I have to say strikes you as being elementary, I can only answer, the greatest need of the profession to-day, not alone in our own school, but in the other as well, is a common-sense comprehension of the elementary facts of homœopathy.

At the very outset it is necessary to have well-defined ideas in regard to the interpretation of the so-called homœopathic law, and the relations existing between the manifestations of drugs and the manifestations of diseases; and, because these two ideas are so intimately associated, your interpretation of the former will depend entirely upon your comprehension of the latter; and no matter what may be said concerning the so-called homœopathic law, it cannot be more or less than is the demonstrable individual relation of similarity existing between the manifestations of drugs and the manifestations of diseases. It is at once apparent how important it is to have a rational comprehension of just what this relation embodies. It is the pivot about which everything in homœopathic medicine revolves; and chaotic, indeed, is the condition of mind of him or her who practices it without knowing well its bearing.

What is the theory?

"In the living organism a weaker dynamic affection is permanently extinguished by a stronger one, if the latter (deviating in kind) is very similar in its manifestations to the former."—*Organon*, No. 26.

Let us take a concrete example,—malarial fever; a disease characterized by the occurrence of chill, fever, and sweat, in more or less completeness, occurring at more or less definite intervals, caused by the inception, growth, maturity and sporulation of a definite organism inhabiting an indefinite number of the red blood-corpuscles of man, and acquired from the bite of an infected diptera.

In what sense is the word "dynamic" used in the above quotation?

Obviously, in the sense of being spiritual, *i.e.*, immaterial.

Is malarial fever a dynamic affection?

Are the effects of drugs dynamic affections?

Can malarial fever be regarded, in any sense, as a weaker (dynamic) affection than are the so-called (dynamic) affections of drugs?

Assuming all knowledge of drug effects to be obliterated, our knowledge of malarial fever remaining as it is to-day, are there reasons to assume that the proving of drugs on healthy human beings, or in any other way, according to modern methods, would develop manifestations any more similar to those of malarial fever than those we now know? or that would even be more similar in their manifestations than are the manifestations of some other diseases to those of malarial fever—say pyæmia, septicæmia, or gall-stone disease?

Hahnemann says what is essentially true when he says: "*Extraneous, noxious agencies possess a subordinate, and often extremely conditional power; but drug potencies possess an absolute, unconditional power, far superior to the former in its ability to produce ill-health (morbid discordancy of the human body).*"—*Organon*, No. 33.

What did he mean?

All things being equal, the size of the dose to the body-weight, a given dose of quinine will always produce tinnitus; in contrast to the fact, all things being equal (the amount of an infection, or the duration of an exposure, to the body-weight, or its equivalent, *i.e.*, individuals living under the same conditions), a given exposure to an infection by malaria will not always produce that disease. In other words, some individuals are immune to disease, and immunity to disease is both natural and acquired; and while natural idiosyncrasy in regard to drug-action exists in man, natural immunity is unknown, and when it is acquired it is never absolute. Furthermore, the effects of drugs are always relatively immediate, while the effects of an infection may be absolutely remote (malaria, rabies, tuberculosis).

I want to lay special stress on the necessity of keeping well in mind a fact as well known to you as to me, and fully recognized by Hahnemann, as is evinced by the foregoing quotation: however similar (superficially) many of the manifestations (symptoms) of drugs are to the manifestations (symptoms) of

diseases, the drug and the disease affections, *i.e.*, the diseases themselves, if we can speak of a drug disease, are fundamentally different, unlike. Because, with this fact kept well in mind, it is a comparatively simple matter to grasp what the relations are that exist between the manifestations of drugs and the manifestations of diseases, and why the provings of drugs on healthy human beings, or in any other way, however complete and scientific, in themselves cannot furnish reliable and positive knowledge of how to use drugs in disease (I use the word "positive" instead of "practical," because practical has a relative meaning, and because I consider the present method as practical, but not positive), and why empiricism must also play its part to stamp them as relatively reliable, and positive, or the reverse.

The law itself expressly states that it is not the affections themselves that are similar, but their manifestations, *i.e.*, their symptoms; the drug and disease affections themselves are not only spoken of as being, in relation to each other, stronger and weaker, but they are referred to as deviating in kind, although Hahnemann elsewhere speaks of the totality of the symptoms constituting the disease, and, as a matter of fact, it does for all practical purposes in making a homœopathic prescription; but we should not allow this to obscure our minds in regard to their true relations.

How is the subordinate and often extremely conditional power of extraneous noxious agencies to be explained?

By the existence of an understood something which is known, when present, as immunity, and when absent as predisposition, idiosyncrasy, diathesis or dyscrasia, for want of a better term.

Theoretically, how is malarial fever to be cured by drugs?

Obviously, in either of two ways. First, directly, by destroying the causative organism in the blood by a drug (poison) that is absolutely harmful to it, and only relatively harmful to the blood itself or the human body in general; and, second, by the removal, or cure, by means of a drug, of the personal predisposition, idiosyncrasy, diathesis, or dyscrasia, or whatever it is, that permits the primary acquirement of the disease and its continued existence. It is obvious that there can be no guide according to which the symptoms produced by drugs on healthy human beings can be used to select a drug

which will cure the disease in the first way, *i.e.*, by the direct destruction of the organism by some substance inimical in its life; pure empiricism or experimental medicine is necessary here. And, inasmuch as almost nothing is known, symptomatically or pathologically, about predisposition, idiosyncrasy, diathesis, or dyscrasia, there can be no reliable, positive guide according to which the pure pathogeneses of drugs can be used to select a drug which will bring about a cure in the second way, *i.e.*, by the removal of the predisposition, diathesis, or dyscrasia; something else is wanted here too, namely, experience; although this is the conventional way disease is said to be cured homœopathically,—by treating the patient, not the disease; and it is here homœopathy has achieved some of its greatest triumphs; and it is here the methods of the dominant school are the weakest; and it is here, undoubtedly, that some of the most important results in drug therapeutics are achieved.

Predisposition, idiosyncrasy, diathesis or dyscrasia may be assumed to be due to nutritional faults or defects, congenital or acquired, and not to dynamic causes in a homœopathic sense; and I have elsewhere ventured the assertion that drug action is not to be explained by the assumption of a dynamic or spirit-like force, but by the chemistry of the drug developing electric conditions, perhaps, but dependent primarily on chemical composition. The practical application of the idea needs no elucidation.

Furthermore, drugs are proved on healthy human beings, although the unhealthy are alike susceptible to their action. While, on the contrary, as has just been shown, the healthy human being, in a somewhat restricted sense, but more especially so from a homœopathic standpoint, is not supposed to be susceptible to disease, some predisposition, idiosyncrasy, diathesis or dyscrasia being assumed to be necessary besides the exciting cause. In practice it is seldom possible to separate these elements, *i.e.*, the predisposing and the exciting cause, the disease and the dyscrasia or diathesis, although Hahnemann took cognizance of them by means of his so-called anti-psorics, and whatever success he may have had in this line could not have come from deductions from the pure pathogeneses of drugs, but only from experience.

How have the results already accomplished been obtained?

and how will relatively reliable, practical results be attained in the future?

While these questions are very pertinent to the subject, their answer involves so much that they can scarcely be touched here. Suffice it to say, the proving of drugs is the essential means to a desired end, but the symptoms constitute general rather than special guides, and it remains for experience to furnish the special guides, or to establish a curative relationship between drugs and diseases (witness the enormous accumulation of clinical symptoms in the *materia medicas*); and for this reason, however pure a pathogenesis is in the beginning, every subsequent writer will illuminate or mutilate it with his clinical experience, and by forcing it into comparisons and contrasts with other similarly handled pathogeneses; therefore, the paths trod in the past will be the paths trod in the future, or so long as the homœopathic school has an individual existence.

The pathology, if I can use the term, and the symptomatology of drugs are one thing, and the pathology and symptomatology of diseases, with their predisposing, contributing and exciting causes, are another thing quite apart, and very much more complex; and between which there exists no natural relation,* but certain accidental ones, now manifested in an apparent similarity in their manifestations, again in an apparent contrariety, and both of which accidental relationships are utilized as guides or suggestions for experimentation in order to determine their value, and neither of which are, *a priori*, evidence of fact. These two principles are not naturally antagonistic, but probably in a sense complementary; the antagonism we have come to feel between them is the artificial creation of man, largely owing, perhaps, to the manner in which homœopathy was launched upon the medical world. The principles of similars and contraries may be regarded in the light of methods of systematized empiricism, in contrast to pure empiricism, and for which the

* Between antitoxin and diphtheria, thyroïd extract and myxœdema, bacillum or tuberculin and the various tubercular manifestations, there is a natural relation; between quinine and malaria, mercury or iodide of potash and syphilis, there is most likely a (undetermined) natural relation; between the manifestations of drugs and the manifestations of diseases which are neither similar nor contrary there is no relation save their common origin in man and different exciting causes, when similar or contrary there is a relationship, but which can only be designated as fortuitous.

proving of drugs on human beings, or a knowledge of their effects as poisons, furnishes the material necessary for their systematic development. This, in my judgment, is the rational place of homœopathy in drug therapeutics; the only place in which it will ever receive general recognition, and the only place which harmonizes with its actual, rational application at the bedside as it is now carried out by the majority of its followers.

In treating malarial fever we do not do so directly by destroying the malarial organism, nor indirectly by removing the predisposition, idiosyncrasy, diathesis or dyscrasia permitting the primary infection and continued existence of the disease, for we do not know how to separate the symptoms produced by the disease from the symptoms produced by the predisposing causes. We treat neither the patient nor the disease; we treat the patient's symptoms, all his symptoms, regardless of whether they are caused by idiosyncrasy or by disease.

What is the cause of the symptoms in malarial fever?

The pathogonomic symptoms are caused, undoubtedly, by the inception, growth, maturity and sporulation of the malarial organism, the interval of the intermission and the character of the paroxysm; by whether the infection is tertian, quartan, æstivo-autumnal, or true quotidian; or by whether it is mixed, giving a complex but pathogonomic symptomatology. But the pathogonomic symptoms, theoretically, are subordinate homœopathically. It is the peculiar, irregular and unusual symptoms that are supposed to predominate for the purpose of a homœopathic prescription; as an unusual type, unusual time of occurrence, unusual immediate cause, things or conditions aggravating or ameliorating, predominance or absence of peculiar symptoms before, during or after, etc., for chill, heat and sweat, as well as the symptoms of the prodrome and apyrexia.

This is called individualization, treating the patient, not the disease.

But is it?

Is it not rather treating both the patient and the disease? or simply treating the patient's symptoms, pathogonomic and individual, with their mutual modifications.

By what is the protean array of the symptoms of disease met?

By means of the similarity of the symptoms of drugs produced on healthy human beings. It is a "far cry" from the comparatively simple origin of the symptoms of drugs to the complex and protean origin of the symptoms of disease. Yet the simple results of the provings of drugs on healthy human beings when similar to the pathognomonic symptoms of disease, modified, masked, intensified, or otherwise changed by an obscure and inscrutable something variously known as predisposition, idiosyncrasy, dyscrasia or diathesis, are said to be an infallible guide for the cure of natural disease according to a law of nature, which explains the cure by the assumption of the substitution of a similar but stronger dynamic drug disease for the weaker (dynamic) natural disease on the one hand, or by the removal of the predisposition, idiosyncrasy, dyscrasia or diathesis, and the natural death of the natural disease for the want of a proper soil or fuel on the other hand; and all of which is characterized as individualization, or treating the patient, not the disease. It is obvious that there are certain irreconcilable, theoretical difficulties here; especially as the idea of dyscrasia, which is a theoretical abstraction rather than a concrete fact, takes the place, in the minds of many, of the so-called pathologic action of the drug; or is confused with something else. For instance, Dr. George Royal, at the last meeting of the American Institute of Homœopathy, in a paper on "The Relation of the Dyscrasias to the Prescription," describes syphilis, scrofulosis and rachitis (which are now pathologic entities) as dyscrasias, probably as an effort to give body and form to Hahnemann's psoric and sycotic dyscrasias.

This is why I say the proving of drugs on healthy human beings, or on any other beings in or out of health, will not give reliable, positive knowledge of how to use drugs in disease; the conditions inherent in the complex origin of the symptoms of disease forbid it, if it were not already forbidden by conditions and difficulties inherent in the proving of drugs, growing out of idiosyncrasies, individualities, variations in the age, sex and social conditions of provers, as well as the personal equation of those who interpret them, not to dwell on the unsettled question of dose.

It requires no great stretch of the imagination to realize that accurate provings, knowledge of prover's previous health rec-

ord, examination of his functions, special organs, secretions and excretions, before, during and after proving, while of the highest importance for the completeness and accuracy of the proving itself, are comparatively valueless in bridging the gap existing between drug affections and diseases, yet they may serve to make more apparent that which is only bridged with more or less incompleteness by empiricism. While the symptoms of a disease and the symptoms of a drug may be very similar in many respects, the drug affection and what we know as the disease may be wholly unlike; witness malarial fever and the pathogeneses of sundry drugs; yet empiricism using the similarity systematically may establish a curative relationship between some of them and the disease. You may think that I have taken an extreme example in malarial fever, but I have not, for as a disease it is well understood, is of wide prevalence, little inclined to spontaneous recovery or to terminate by death, and is singularly susceptible to drug treatment.

All this is why I have said that when the new provings are made they will satisfy the requirements of the theory no better than the old ones have done. The strenuous endeavor to reduce the symptoms of many provers of a single drug to a fixed and common denominator, even with the aid of clinical symptoms and clinical deductions, has not accomplished in the past the ideal precision and certainty in prescribing, and there seems little reason to anticipate that any present or future provings will be better adapted to the purpose; more especially as the homœopathic theory not only does not contemplate, but, in a negative sense, actually forbids a like reduction in the symptoms of individual diseases, even if it were possible to practice, but something like which frequently, unconsciously, actually comes to pass, as is exemplified in much routine homœopathic prescribing, or what Dr. Goodno would probably call "specific (homœopathic) treatments."

SOME SELDOM RECOGNIZED FACTORS IN CARDIAC DIAGNOSIS.

BY EDWARD R. SNADER, M.D., PHILADELPHIA, PA.

IT is a wise procedure to take account of stock occasionally, and to ascertain whether certain recognized procedures and methods in the diagnosis of diseases and conditions affecting the heart are fully adequate to the demands we make upon them, and whether we have the proper amount of mental and clinical capital to successfully acquit ourselves of our duty. Every physician works more or less in ruts, whether it be in the application of therapeutic measures or in the making of a diagnosis. Routinism is the inevitable characteristic of the busy human mind, when it is not of a fanciful or ultra-speculative turn. Now, if we would have our ruts right, the work that makes the routinism of ruts possible,—the preliminary, the foundational work, if you please,—must be in the highest degree broad, full, varied, complete, exhaustive, else our routinism in method will be hardly worthy the name of effort.

We all realize, theoretically, at least, the importance of the heart in all acute maladies, and in most of the chronic ones, and we, of course, investigate it—but how? Most of us, I am sure, in a routine manner, without special care, without any conception of what we anticipate finding, and with only the vaguest conception of the possibilities that may be back of the knowledge that can be gained by a careful, systematic examination, with our mental eyes wide open, and our intellects keenly alive and ready for the assimilation of any information obtainable.

After the information is obtained, do we fully realize what exquisite judgment it takes to analyze and synthesize, and to ultimately draw a correct conclusion, with all its weight of therapeutic possibilities and its burden of prognostic importance? Our ordinary routinism teaches us to examine the pulse. If we failed to do this routine act we would feel guilty of a crime. We examine the radial pulse, and we think we do so intelligently, for as a profession we have been examining pulses for centuries, and we ought to know how to do it. Why,

we knew all about the pulse before we knew that blood circulated in the arteries; yes, when it was believed that the vessels were air-channels; and the pulse characters were as well described then, and even better, I sometimes think, than at the present day, when the sphygmograph is supposed to tell us so much, and does not. Certainly there ought to be no trouble in securing reliable information from a method that the medical profession has practised since the days when the Parthenon of Athens was building! But this routinism of pulse examination is fraught with great possibilities of errors of conclusion as to the action of the heart. We think we examine the pulse in order to ascertain the condition of the artery, the force of the blood stream, the tension of the vessel, the blood pressure, so-called; and we judge of the rapidity and of the slowness of the blood stream, of its irregularity or regularity, of its evenness, of its inequality, of its intermittencies, and try to find out whether the pulse-wave is long or short, or whether it humps itself in dirotism or collapses as in aortic regurgitation, and whether the vessel itself is arterio-sclerotic or there are calcareous plates in its walls. Many of us judge that we can thus obtain an idea of the true circulatory status of the individual we are examining. We can obtain much valuable information in this way—information, too, that cannot be obtained in any other manner; but I maintain that the radial pulse does not give you a correct conception of the heart's power as a whole. Where, pray, do you feel the pulse of the right ventricle? Does not the right heart have as much to do with the circulatory harmony as the left? Is not a competent right ventricle as necessary to perfect equilibrium in the blood circuit as is the spinal cord to the performance of the motor functions of the brain? Just here, I contend, comes in one of the fallacies of faulty routinism in examinations. It is an unjust assumption that the action of the heart as shown by the radial pulse is a correct interpretation of the action of the heart as a whole. Practically, in many instances, at least, the inference that because the pulse shows fair action on the part of the left ventricle, therefore the right is doing corresponding work, is false. Clinical experience daily negatives any such assumption. No, the heart as a whole must be interrogated, and the radial pulse must not be assumed to be the criterion of the power of the heart.

In the examination of the pulse itself we are so in the habit of routinely interrogating it that we fail to get out of the examination all there is to be obtained in the way of information regarding the condition of the artery; and if we fail to appreciate that the artery is not normal, we shall often blunder in considering that we have fair or good function in the left ventricle. If we do not recognize the stiff artery of atheroma, we may judge that we have a strong pulse-beat; if we do not note that the vessels are arterio-sclerotic we may miss the diagnosis, not only of the condition of the left ventricle, but also that of a chronic interstitial nephritis. The pulse, under these circumstances, often conveys the idea of strength, when in reality the heart may be already flying signals of distress that would be plainly evident were we to interrogate the heart as a whole. An examination of the pulse should never be made carelessly, but always with a conception of what can be learned and of the significance of the information that can be secured; and not only as to the possible condition of arterial tension and the extent of the motive power of the left ventricle, but as to its indications as pointing not only to arterial disease, but as well to general maladies. A mere perfunctory pulse examination is almost worse than none at all, for a mass of possible corroborative evidence is missed where it is easily available. I say corroborative evidence advisedly, for, except in instances where the pulse is absent, the information to be derived from an interrogation of the pulse alone is seldom, if ever, more than corroboration of what you find by direct examination of the heart. Indeed, I can go still further, and say that this pulse information is often not even corroborative, but is deceptive, an apparently full pulse being maintained when the heart is under the greatest kind of stress. Remember, too, that every man's pulse is a law unto itself, and that you have no standards of comparison, and you must judge of the condition of the patient's vaso-motor system and the size of his arteries before you are in a position to say that an individual pulse you are examining is or is not weak or strong, and whether the apparent weakness or strength is not due to vaso-motor relaxation or spasm. A man with big arteries, with even a small blood stream, will show a fair pulse that might be considered strong, while the left ventricle may be irreparably dilated. A

small artery, too, with a good, forceful heart behind it, may simulate the increased arterial tension of Bright's or the forcible action of hypertrophy. We should never neglect to ask the pulse questions; but we should know the language it speaks, and use the answers to corroborate information received from a direct examination of the heart. We must examine both the right and left ventricles.

Physical signs indicating the existence of organic disease are of great importance, and it is true, beyond peradventure, that we cannot make a diagnosis of the form of lesion without them; and, indeed, we cannot make even an intelligent guess as to the nature and pathology of the lesion without the information furnished us by percussion and auscultation; and with the knowledge thus obtained we are armed, it is true, with the power of accuracy in therapeutics and in prognosis; but I must insist that, while we cannot make a scientific diagnosis without the physical signs any more than we can make a diagnosis by symptoms alone; that in a certain class of cases, at least, the symptoms are nevertheless of the greatest possible value in determining the degree to which the organic lesions, if they be present, have injured the working-power of the heart. Both signs and symptoms have their proper place, and neither should be ignored, if you would have definite knowledge concerning the organ that is the foundation of all the nutritive, life-giving, life-sustaining work of the human economy, the heart. The physical signs diagnose the nature of the disease; the symptoms often tell the extent of damage done. This is simply a broad contrast, and only partially conveys an idea of the relationship of signs and symptoms: for they both have a more extended sphere than can be indicated in such a wide generalization. Such a generalization, however, will help us the better to have a working view of the more especial sphere of the signs and symptoms.

One of our first duties, when we examine a heart, is to ascertain whether or not the organ is organically diseased. There are four steps in our progress in heart examinations. The first great step, when we began our first examinations—I mean, now, the days when we were serving our novitiate as doctors; when our sheepskins were still redolent of the lamb they so kindly tried to cover; when the mantle of M.D. first fell upon our

shoulders—the greatest problem was to determine whether there existed disease of the heart. In other words, we could find no diseased hearts. The problem of discovering and diagnosing cardiac disease is an exceedingly difficult one, and some have never acquired the ability, and never will. After many, many mistakes, there came a time when we could with positiveness declare that a heart was diseased, and we were temporarily happy. At first we could discover no lesions, and as a second step we began to find them; and from this position we went still further, and found them possibly where they did not exist; for experience led us to discover many peculiarities about the heart. In other words, we became so expert that it was seldom possible to find a heart that was perfect; and this is the natural tendency when we become thoroughly acquainted with the workings of an organ. But we had a still greater lesson to learn, and then came the third step; and that was to find a normal heart in spite of the many aberrations of function and all the other hundred-and-one factors that are important in one case and not in another. We had now learned the power of discrimination, after many bitter failures; and this was the hardest lesson of all to learn save one. If you will go back in memory you will find that you passed through exactly this process—first, you could find no lesions; then you found many; and then, again, you found normal hearts. Of all the lesions affecting the heart we were most gratified with the discovery of murmurs; and we now realize that the discovery and localization of murmurs is simply child's play, compared with the problem that confronts us when we attempt to tell the condition of the heart-walls, the heart-muscle—and this is the fourth great step. This is the higher diagnosis, for it brings to the fore the second reason that makes us examine the heart, and one that can never be attained by perfunctory examinations. The first was to tell whether the heart was organically diseased, and the second is to tell the degree of its competency as a pump and as a vital organ,—whether it is the seat of disease or not. This is, indeed, the very acme of achievement in cardiac diagnosis. This acme is not achievable, however, without the ability to diagnose the existence of lesions. And it is just here that symptoms, in a certain class of cases, assist us in coming to a conclusion as to the heart's oncoming

possible irremediable bankruptcy. It is easy enough to tell that the heart is failing when a patient is already in the throes of death, but then a diagnosis of any kind is of no service save to fill out, scientifically, a death certificate. By estimating the heart's competency, I mean estimating it when the subject is about, upon his feet, possibly thinking himself well, or when he is suffering from an acute illness from a self-limited disease, as typhoid fever, pneumonia, or even contemplating a surgical operation, and you wish to determine whether, barring unexpected complications, the heart will see the patient through to recovery. This is very often possible. I mean also to apply this heart-measuring to the consideration of that great array of diseases, such as phthisis pulmonalis, emphysema, chronic bronchitis, tumors in the chest, accumulations of fluid in the pleural cavity, the Bright's lesions, and a host of other diseases that may show their first signs of surrender to death in the circulatory sphere. When the heart itself is diseased, irrespective of these chronic maladies, the early discovery that the heart is under stress may lead to a restoration of the functional power of the organ and a return to comparative health, and at least to a prolongation of life.

At such a stage as this, and even much later, the pulse may not appear abnormal, and if you trusted to it alone you would feel that your patient had very good heart-power. In cases where the symptoms of dyspnœa and deficient kidney elimination and venous congestion appear, you have indubitable evidence that the right heart is not competent to keep up the part of the circulatory work assigned it. It is flying signals of distress. The books tell us, and clinical experience tells us, that when the first sound of the heart is shortened,—is as high or higher pitched than the second sound, and the boom of the first sound is gone,—the heart is declaring its inability to perform its work. These are apparently little points; but there is possibly no combination of physical signs connected with the heart that is so little appreciated, and yet so overwhelmingly significant, offering on the one hand the greatest opportunity for the employment of proper therapeutics, and, unrecognized or unappreciated, fraught with the momentous issue of life itself or its continuance. Yet, with our routine methods of examination, one often fails to appreciate the magnitude of these

signs until there is superadded easily recognized symptoms. If the heart be organically diseased, the physician is always on the watch for the development of some one of the pathological sequences that commonly or occasionally supervene in the course of the various maladies that affect the heart; but many do not have any apprehensions whatever if they have failed to find the gross evidence of organic disease. This is another of the errors of routinism in examinations, the lack of the conception of the possibilities that may occur in any case under your care. It is not at all necessary that a heart present evidences of organic disease to need careful watching. A heart must be conceived of not only as a mechanical pump, but as a vital organ, subject to all the vicissitudes of function that are known to take place within certain limits in every organ of the body. If we would correctly estimate the heart's power, we must have the conception that it must be measured as to its capacity to do its work independently of whether it is the seat of a discoverable organic lesion or not. As a practical clinical fact, there are many hearts that are structurally diseased that are more competent to do their work than hearts that are not diseased; at least we cannot find in them the classical signs of disease. It may be argued that such incompetent hearts are diseased, and possibly this is a correct assumption, but we are as yet unable to place a tag on them and name their specific deficiency. We only know that the walls are affected, or that the muscular power is deficient—I say we know, but perhaps I should say we suspect, one of these two conditions, or the one interwoven with the other, to be present. Perhaps you may say the triad of symptoms,—a short first sound, a higher pitch of that sound, and a loss of the booming quality, excluding, of course, fatty degeneration and myocarditis,—are the first stages of dilatation. Possibly so; but the other classical signs of dilatation are lacking. But whether those signs are lacking or not, or whether we can name the lesion or not, the practical fact from a diagnostic and therapeutic standpoint is that that heart, be it diseased or not, is not doing its work properly, and sooner or later its deficiency will be declared by indubitable symptoms, or perhaps by a sudden surrender, under the stress of extra labor or emotion or an acute or chronic malady. This character of cases must be diagnosed almost exclusively by the

physical signs; but there is still another class where the symptoms are of the greatest possible value in determining the heart's working power. When the heart has been hypertrophied, either secondarily to disease within itself, or secondarily to some obstruction in front of it in the lungs or some more distant organ, these signs are seldom available as indicating impending cardiac bankruptcy, except at such a time as death is impending. When the heart has been previously hypertrophied in a succeeding dilatation, unless it be just bordering upon the degree that produces paralysis of the ventricular walls, the first sound may be quite big; indeed, it may have more boom to it than a normal heart, and it may suggest the idea of a powerful organ, and at the same time its walls may be so stretched by dilatation that cardiac failure is already at hand. This is notably true of the heart of interstitial nephritis and of vesicular emphysema, and of some of the left-sided valvular lesions. As I have intimated before, we are at a distinct disadvantage in measuring the heart's capabilities, because we have no standard of comparison, as we have in the lungs, and, therefore, we cannot rely wholly on the physical signs in this class of cases, for those that would indicate a good heart in one man might mean a very bad one in another. We must measure the man belonging to that heart, if you please, and we must measure the work that lies before his cardiac apparatus, and estimate truly the amount of obstruction to be overcome by the heart caused by the lesions of the diseases that the man has to contend with. It is not enough, then, to examine the pulse and the heart, but we must examine the man, and we must ascertain the cause of the cardiac stress, whether it resides in the heart itself or outside of it, and whether it be vaso-motor or intrinsic. These patients with big hearts and few physical signs often present a good radial pulse, and that, with the considerable boom still left in the first sound of the heart, is likely to lead us astray in some instances, if we do not have the symptoms to aid us. Fortunately for the patient, symptoms usually soon appear that are just as diagnostic of weakness of the heart as are the classical physical signs, and the most notable of these are dyspnoea, venous congestion, diminished urine (except in cases of interstitial nephritis), and general bodily weakness. Close upon the wake of these symp-

toms follow oedema of the ankles, enlargement of the liver, and possibly albuminuria. When decided dropsy appears, he who runs may read that the right ventricle is not performing its part of the circulatory work, no matter what the left is doing.

It is perfectly evident to you, now, that I have attempted briefly and imperfectly to outline only some of the many points connected with cardiac diagnosis; that most of our heart examinations have been imperfect, less from lack of knowledge than from a faulty routine, born of hurry, and possibly an imperfect analysis of the possibilities of the classical methods that led to a routine way of interrogating hearts. A huge volume might be written upon the subject; but if I have drawn your attention to but two or three points, and have impressed their value upon you, I shall be satisfied. I have endeavored especially to insist upon pulse examinations that shall be preceded by a conception of all the possibilities of information that may be obtained from an interrogation of the pulse, and have tried to convince you that in the vast majority of instances, at least, the information furnished by the pulse was of a corroborative nature, so far as the left ventricle was concerned, and only suggestive and often deceptive of the condition of a right ventricle, and that only the knowledge concerning blood tension and the condition of the arterial walls, and of the state of the vasomotor system, was to be relied upon as furnished by the pulse. The second point I have endeavored to bring out was that the heart was not to be ignored as a symptom and a state-producing factor simply because an examination had shown it to be free from any of the known organic diseases, and that a heart should be interrogated as to its specific ability to do its duty whether it was diseased or not, some hearts organically diseased being practically better organs than those showing no signs of classical disease. My third endeavor was to show that in a certain class of hearts, mostly those in which hypertrophy had been present, the symptoms were as reliable in determining weakness of the heart as were the physical signs. Altogether, it is simply a plea that we shall always keep our wits about us, and receive knowledge from all sources, and have a just conception of what we can and what we cannot do with certain of our methods of diagnosis.

We all know these points theoretically. But when we examine a heart we must sense them all over, not as simple intellectual facts, but as vital, dominant motives, filled with enormous possibilities, therapeutically and prognostically.

AN INVOLUNTARY PROVING OF HYDROCYANIC ACID.

BY W. S. SEARLE, M.D., BROOKLYN, N. Y.

(Read before the Medical Society of Kings County, N. Y.)

In March, 1902, Mr. H. was a student of chemistry in the laboratory of the "Poly," and accidentally inhaled the fumes of prussic acid. The immediate results were headache, frothy saliva, vertigo, and muscular prostration. During the evening the headache increased till the brain felt stupefied. He did not at that time suspect the real cause of his ill feelings, nor, indeed, till months afterward. He slept as usual, but awakened with still more severe headache and an acute pain, or, rather, distress, in the spine, between the scapulæ. He had such vertigo, also, that it was difficult for him to walk. He felt very weak and a little nauseated.

On consulting me, he described the sensation in his head as like that of a heavy weight on the vertex. He was amnesic, also, and made frequent mistakes in both speaking and writing. All his symptoms were aggravated in the morning, abated during the day, and were relieved in the open air.

A month later he again called, complaining most of the head and spinal pain, which was aggravated by walking. Blood oozed from his nose and mouth, he was weak and cold, his pulse was 40, and his temperature 96°. Otherwise, he appeared quite well—all his functions being normal—and yet he rapidly lost twenty pounds in weight.

As I was still in ignorance of the accident, I was much puzzled by his condition, but prescribed *carbo veg.* 30, under the influence of which both his pulse and temperature rose somewhat, but did not reach the normal standard, nor did it favorably modify the case otherwise. The headache became

worse, a full sensation in the forehead developed, and tinnitus aurium was added. Blood seemed to exude into the nose and throat.

On May 18th I prescribed *cactus g. o.* This drug only served to aggravate the symptoms, though the spinal pains disappeared under its use. The same drug in the 6th did not exacerbate, but neither did it help.

On May 23d I gave drop-doses of *cannabis sat. o.*, which afforded instant relief. The pulse at times rose to 60, and the temperature became normal, hæmorrhages ceased, and, for a time, he seemed well.

Now, for the first time, I was informed of the poisoning, and began to understand the etiology of my case.

Mr. H. now stated that he first observed the low pulse and temperature about a month after the accident, though both probably existed from the outset.

He had an acute coryza while away from home on a brief visit, and, on trying his temperature, found that he could not get the mercury above 95°, while the pulse stood at 40.

On June 1st the patient reported as follows: Weight on vertex gone; no more epistaxis nor bloody saliva; head still muddled; can't sleep after 4 A.M.; pulse about 50; temperature ranges from 97° to 98°. *R.* *Cannabis o* continued.

June 20th. Pulse, on waking, 42. By noon it reaches 60; sleeps longer and gains in strength; no change in weight; he complains of a foul taste on waking in the morning.

My prescription was *kali phos.* 3, but without perceptible effect. During the summer Mr. H. went to the hill country of Connecticut, and lived carefully without medicine. On his return in early October he again called, in somewhat better condition. As soon, however, as the weather became cool, his temperature and pulse were both depressed. The pulse would fall to 40, and the temperature to 97°. His muscular strength was fully restored, and he endured long tramps without fatigue. He did not gain in weight, however, being at least twenty pounds lighter than was normal for him. I gave him *cup. arsen.* 3, three times daily, which appeared to have immediate effect, and he is now in normal health with the exception that as soon as the weather becomes cold his pulse and temperature fall below the normal.

I was a good deal surprised by some of the features of this case, even after its cause was revealed.

True, the headache, muscular weakness, depressed temperature and pulse, the frothy and bloody saliva, the passive epistaxis, are all classic features of poisoning by this drug, but its action is so rapid and overwhelming that I did not look for such persistent effects.

Later, however, I recalled the protracted influence of sunstroke and lightning, which often lasts for years, though even more instantaneous.

Another very noticeable fact, and one for which I was quite as unprepared, was the speedy and permanent relief obtained from the homœopathic use of *cannabis sat.*,—a drug which, as we all know, seems to spend its main force upon the mucous membrane of the genital organs. The above experience, however, would seem to indicate that it has a far wider and important range.

Again, I remark the fact that the simultaneous depression of the pulse and temperature throws some light upon the long-mooted and still unsettled problem of bodily heat. While it cannot be held to prove any theory, it certainly tends to verify the chemical explanation. Should I have opportunity, I shall experiment upon Mr. H. with oxygen inhalations. These should, it appears to me, raise the temperature without stimulating the pulse.

THE INHALATION TREATMENT OF CONSUMPTION.—Dr. W. B. Clarke says this inhalation treatment of consumption is a fraud. He tried the method long enough to prove its worthlessness. If it be a fraud, he has done us a real service by pointing out its utter worthlessness, because it is astonishing how many, apparently intelligent people, are being duped by the statement that by simply putting the remedies upon the seat of the disease, instead of in the stomach, consumption may be cured. We have always thought that it was silly to prescribe a remedy for tuberculosis upon the theory that any drug possessed such a specific relationship to the bacillus that it could act upon the germ in pulmonary tissue to such an extent as to destroy it or to remove the lesions caused by it. Dr. Clarke goes farther than this, and says that persons with weak or diseased lungs are often severely injured by the cabinet and pneumatic poison-laden respiratory gymnastics carried out by or under the direction of the inhalation manipulators.—*The American Physician*.

EDITORIAL.

EDUCATION.

At the present time very much is being written on the subject of Education, to all of which the unbounded enthusiasm shown in the various collegiate foot-ball contests furnishes a pleasing running commentary. On the commentary we will not comment, further than to say that it shows very plainly how inadequate is the study of the "humanities" to eradicate the innate savagery of our human nature. It is a case of atavism; and if we imagine the foot-ball to be a cocoanut, it will not be difficult to call up mental pictures of the early contests of our simian ancestors before brawn had yielded to brain, and while brute force and cunning still held sway.

But it is of education we wish to write. We have been rejoiced to see from various quarters protests against our present system, particularly as pursued in our public schools. While we think that a certain learned educator took an extreme view in laying upon the public schools the entire blame of the evils everywhere manifest in the character of the masses as component parts of our social fabric, we feel assured, as we have often said, that the imperfect, superficial kind of education there imparted is the most potent factor in the production of these evils. In them the foundation of character is laid, and in them, in the vast majority of cases, alone; and if the foundation is faulty, what can be expected of the superstructure?

Here, as in every other subject, no satisfactory or useful argument can be engaged in until there has been a thorough definition of the terms used. What is meant by Education? The word, as commonly employed, even by those who argue on methods and systems, is vaguely used to include two objects which should be kept separate and distinct when considering the best means for their attainment. Education is, in the one instance, the acquiring of knowledge; in the other case it is training the reason. By reason we understand not only the

mental, but also the moral and emotional sides of a man's nature, for we look upon the moral and emotional as merely reflexes, physiologically speaking, of the mental.

Now, while it would seem that the bare acquisition of facts would in itself be calculated to tend to the cultivation of the reason, a moment's thought will convince us that such can be the case only to a very limited degree, if at all. The acquisition of knowledge depends entirely upon memory, which itself is founded upon the property of our physical bodies to undergo molecular changes in muscle as well as in brain, to retain them for an indeterminate period, later to be recognized as having been previously experienced. It deals, therefore, entirely with precedents, and furnishes only the materials upon which a different faculty of the mind (to make use of a vague and incorrect expression) is called upon to act when the reason is to be cultivated. A system, therefore, which is built upon the assumption that the end and aim of education is the acquisition of facts must be regarded as faulty, if the cultivation of the reason, as above defined, is the true object to be sought. Herein lies the essential vice of the prevailing systems of education—pre-eminently of our public-school methods. It is easy for the upholders and defenders of this system to fling at the heads of objectors the charges of "ignorance of their methods," "failure to examine their system," and "prejudice," but it is not so easy for them to suppress the testimony afforded by the results of their system, as set forth in the examination papers. Facts, facts, facts, is what the system demands, and what it gets; but the lessons taught by these facts, the basis these facts furnish for further progress,—these considerations lie outside of their system.

It would lead us too far to speak of the multitudinous facts in multitudinous subjects presented to the scholars—chaff for wheat, stones for bread—only to be gotten rid of as soon as possible when passed examinations render their retention unnecessary.

We see this Gadgrind influence permeating our whole educational life. The practical is everywhere opposed to the theoretical; and even in our higher institutions of learning the practical aspects of a branch of study is allowed to determine its enforced or optional pursuit. We forget too often that theory alone can render rational practice possible.

But to come to that education which includes the cultivation of the mental, moral and emotional sides of man. As we above affirmed the physical molecular basis of memory, so here again we demand the recognition of physiological facts as the only true guide in formulating the outline of a system. All our incoming impulses through our senses reach the central nervous system, and there have open to them many pathways by which they may manifest responses, either in the way of visible movements of the external body or by invisible molecular changes giving rise to new impressions or thoughts. These pathways in the child are at first undetermined, except as they are modified by heredity, and are, therefore, capable of being influenced by education. In cultivating the reason we will, therefore, seek to open up as many pathways as possible for the incoming impulses, whereby new connections between remote neurons (nerve elements) are formed. We thus put within the grasp of the mind, or ego, the whole mass of neurons within the central system, with all possible connections, thereby enabling it to *think*, which is, in reality, nothing more than the recognition of connections between the states of consecutively affected neurons.

To illustrate: When giving a fact, which is but a sense perception of another, instead of allowing it to remain as a dead fact, with its accompanying molecular changes impressed on the tissues, to be recalled by memory, we use it as the starting-point of many responses throughout the central system, making its diffusion as wide as possible, according to the categories of cause and effect, similarity and dissimilarity, antecedent and consequent, etc. By gradually, but persistently, causing these pathways to converge on responses concerning the true, the beautiful, and the good, we cultivate at the same time the moral and emotional natures, and *give them a permanent physical basis in the nervous system.*

At the *Congress About Boys*, held lately, Dr. Winthrop T. Talbot, director of a boys' school at Holderness, N. H., asserted his belief that every moral obliquity and mental deficiency in a youth rests upon some physical cause; and that the moral and mental cannot be separated from the physical. He said, in illustration: If a boy's circulation is sluggish he learns slowly, and is called, on that account, stupid. This makes it

easy for him to lie. Lying becomes habitual,—all because of poor circulation.

This is quite in accord with our present line of thought; but we go one step farther and trace the effects of poor circulation back to its effects upon the central nervous system, which has been allowed to become habituated to abnormal, so-called immoral, responses.

It will be seen from the foregoing that we believe that in the education directed to cultivation of the reason, or the development of true culture, the essential consideration is not *what* is taught, but *how* it is taught, and that there can be no effective system of education which does not recognize as its basis the development of the physical units of the nervous system—the neurons—according to physiological, not psychological, laws.

GIFT-BEARING GREEKS; A SEQUEL TO THE GOLD MINE IN FRONT OF THE DOOR.

SCARCELY had the sheets of our November number entered our bindery when we were favored (?) by the receipt of a communication from a promoter. His scheme required only a paltry half-million to float it. Briefly, it was stated that the proposition was submitted to physicians only, for whom a block of stock is especially reserved. As we read this we heaved a sigh of gratitude to think that our noble profession was at last appreciated. Only 8 per cent. per annum was guaranteed, but we were comforted with the hope held out that, after all, the earning capacity of the new company was too conservatively estimated, and that it was not unreasonable to expect annual dividends of 100 per cent. If, at the end of one year, developments were such as to make us dissatisfied with our investment, we only had to ask for our money, and we would receive it forthwith.

Surely has the medical profession fallen in intelligence so low that there is even one man living who expects to catch a sufficient number of physicians by such promises to even pay for the postage on his circular letters!

The circular did not state who guaranteed the 8 per cent. per

annum. It did not give the financial strength of the guarantor. Nor did it tell us how our capital was to be returned to us in one year if we were dissatisfied.

It did seem strange that he should pick physicians out as investors. Of course, he gave plausible reasons for seeking their aid. But as Ben Franklin once remarked, "No men are so unreasonable as those who have a reason for everything." We might add, in parentheses, that paranoiacs have good reasons for all their crankinesses.

The amount to be raised was, as we stated, but a half-million dollars. There are many men in this rich country of ours abundantly able to subscribe the full amount. Moreover, capital is so greedy for good investments that everything of merit is seized upon as soon as its prospectus is announced. Indeed, we might say that, given a scheme with a true guarantee back of it, such as we were offered, and capital would be seeking it, instead of it the capital. Again, as the worldly possessions of doctors go, we believe that it would take at least five hundred of them to secure the half-million. Five prosperous business men could and would put in the entire capital if good security against loss was offered.

And here comes another liberal offer! It is prefaced with the warning, "This is the last opportunity you will have to purchase our shares at ———. . . . We advise you, therefore, to take advantage of this offer at once." As an inducement we read further on, "We will earn at least 10 per cent. per year for you on your investment or return you your money." "Your dividends should amount to at least 30 per cent. during the first few years, and increase gradually thereafter."

Almost as we write we receive the following letter, which we present without comment, permitting our readers to draw whatever conclusions they may see fit:

Dear Sir: You have been recommended to us as a suitable person to join in the promotion of the ———. *If you are in a position to interest others** in a legitimate investment, and will write us to that effect, we will submit to you our plan, and give you an opportunity to join with us. We are carefully selecting

* Italics ours.

a limited number of persons, outside of the officers and directors, to whom we will make the offer. If you would consider favorably such a proposition, we would be pleased to submit it to you.

Kindly let us hear from you at once.

Yours truly,

The _____ Company.

By _____,

Secretary.

THE TREATMENT OF THE ENDOCARDITIS OF CHOREA.

BRAMWELL, in the first number of his "Clinical Studies," expresses very decided views respecting the management of choreic patients who exhibit cardiac murmurs. As is well known, there is a growing conviction among pathologists that the heart murmurs of chorea are due, in the majority of instances, to an endocarditis, that lesion being found in practically all cases of patients dying with chorea. It has, furthermore, been noted by the elaborate investigations of Osler that this endocarditis may be found post-mortem, even though no murmur was discoverable during life. Osler's analysis also demonstrates that while, as is currently believed, the murmur disappears with the subsidence of the chorea, if trouble is taken to examine the hearts of such patients two or more years afterwards, permanent valvular lesions will be found in 66 per cent. These facts bring us face to face with a serious problem. It is a common practice to treat choreic patients by allowing them all the fresh air possible, and insisting upon a certain amount of exercise. Absolute rest in bed is enjoined only when the patient is too sick to go about. Accepting the teachings of the more recent pathological investigations, one should treat all cases of chorea presenting cardiac murmurs as he would cases of endocarditis,—by absolute rest, not only during the continuance of active symptoms, but also for some time after their subsidence. Bramwell expresses himself very decidedly on this point, and condemns in most emphatic language the advice of exercise so thoughtlessly given by most physicians.

The tendency of the day is to make physical examinations more searching than formerly. One can never be assured

that a cardiac murmur does not exist in a case of chorea *until he has examined the heart with the chest bared*. Even then it is possible that a lesion may exist and present no clinical manifestation of its presence. The conclusion that we should not permit choreic patients to be treated as office patients seems to be rational.

THE NON-OPERATIVE TREATMENT OF CANCER.

ULTIMATELY, in every case of cancer, the question of operation must arise; and when the decision is against such interference, a grave problem confronts the medical attendant. In view of these facts, the discussion of the treatment of inoperable cancer by the members of the British Medical Association during their recent session is of great interest to every member of the profession. Morris, of London, in opening the debate, was careful to define as inoperable those cases in which the disease cannot be entirely eradicated by a cutting operation or by the actual cautery or any escharotic aiding the knife. Though cancer, using the term in a general sense to include all malignant new growths, may be regarded as at first a local disease, there must be four groups of cases which are of necessity inoperable, viz.: (1) primary cancer affecting inaccessible parts and organs; (2) primary cancer extending beyond the limits within which complete removal is possible; (3) rapidly-growing or widely-infiltrating neoplasms of exceedingly virulent character; and (4) cancer recurring in multiple metastatic foci or in parts beyond removal.

The absence of definite knowledge as to whether or not cancer is of parasitic origin interposes no bar to experimental investigation along clinical lines, and, in consequence, an extraordinary number of empirical methods of treatment have been proposed. Naturally, toxin and serum therapy has occupied a prominent place. The mixed toxins of Coley, which exerted no influence whatever upon carcinoma and but little upon sarcoma, have been followed by a number of other agents calculated to exert a destructive action upon cancer-cells. The injection of cancrin, an aqueous solution of neurine citrate, suggested by Adamkiewicz in 1893, has yielded no results on

extended trial. An anti-cancerous serum, obtained from geese inoculated with cultures of the blastomycetes obtained from human cancer, was introduced in Paris by Vlaieff two years ago; it was claimed that it would cure, if used before ulceration or glandular invasion; but even were this claim borne out by results, the method would seem to offer no advantage over the knife. Indeed, as stated in the report of the Cancer Investigating Committee of the Harvard Medical School, animal inoculation and culture experiments with human cancers have all been followed by negative results.

Subcutaneous injections of substances other than serums and toxins have been tried extensively. Dilute acetic acid, alcohol, bromine, methyl-violet, oil of turpentine and arsenious acid are among the remedies tried without producing any reliable results. Webb, of Melbourne, basing his practice upon the theory that cancer is due to crystallization of cholesterine from the living cells, injected cholesterine in soap solution, giving at the same time thyroid extract by the mouth, and thus cured a recurrent epithelioma of the face. A second case was unaffected; but a third, a cancer of the breast, disappeared in six weeks, recurring in six months, and again disappearing under treatment. Subsequently, losing faith in cholesterine, Webb used injections of soap, either superfatted or yellow bar soap, in drachm doses of a warm solution just thick enough to blow bubbles when boiled. Thyroid extract is administered at the same time.

Local applications have, of course, been much in vogue. Etheridge, of Chicago, has applied calcium carbide, the crystalline substance which produces acetylene gas in the presence of water, to cancer of the uterus. After curetting the uterus and applying the Paquelin cantery and irrigating with hot water, the cavity is made as dry as possible, a piece of calcium carbide the size of the last phalanx of the thumb is inserted, and immediately the vagina is packed with iodoform gauze. The remnants are removed and the process repeated every three days until a clean ulcer is formed, which in one case healed and remained well. Methylene blue in 20 per cent. solution, formalin and nosophen have been used, but without notable result. For the relief of pain in ulceration, orthoform has been extolled; it is a local anæsthetic, and not poisonous, and

keeps up its anæsthetic action for twelve or eighteen hours or more. Morphine or codeine, or an ointment of opium mixed with conium and stramonium made from extracts of the fresh leaves, are sometimes very beneficial. To correct fetor, nothing is much better than an ointment of vaseline and eucalyptol and iodoform, or a lotion of alcohol and water in the proportion of 1 to 3, equal parts, or even stronger, if it can be borne.

Beaston seeks to arrest cell proliferation and to promote and hasten the fatty degeneration of the cancer bodies (which he regards as cells undergoing mucoid degeneration) by a free administration of thyroid extract, together with excision of the tubes and ovaries. The method has induced complete disappearance of the disease in some cases and great improvement in a still larger number, but these results are by no means uniform. Thyroid extract alone has favorably influenced a few cases of cancer. Considerable improvement has been attributed to freshly prepared lymph-gland extract.

The trial of physical methods has been purely empirical, and theories respecting their mode of action are based upon the results of their action.

Phototherapy, the light treatment introduced by Finsen, has been used with success in both the non-ulcerated and the ulcerated forms of rodent ulcer. It is not applicable to large rodents, as it is impossible, on account of the small area operated upon at a time, to keep pace with the spreading margin. The blue, violet, and ultra-violet rays, all of which are destructive to many forms of bacteria, predominate; but the ultra-violet rays have but little penetrating power, the power increasing with the wave-length. Short waves are stopped by the blood, so that it is necessary, in order to get them to penetrate the skin, to render the part bloodless by compression. Owing to the feeble penetrating power of these rays, only the most superficial forms of cancer can be treated by them.

A method of treatment which, so far as present knowledge goes, has much the same features as Finsen's light treatment, is the electric-brush discharge from any high-tension electric machine. The electric-brush discharge yields invisible ultra-violet, visible violet, and blue rays, with a small admixture only of heat rays. The object of this method is to obtain a blue discharge from an electrode shaped so that pressure can be ap-

plied to the surface. Blacker describes the reaction on the skin of the electric-brush discharge or high-frequency apparatus as resembling that produced by the sun; it is produced quickly and heals quickly, whereas the reaction produced by the X-rays appears slowly and heals slowly.

The X-rays differ essentially from the foregoing methods. The violet rays are bactericidal; the X-rays are not. Indeed, under the X-rays many forms of bacteria flourish. Their great penetrating power also widely distinguishes them from the violet rays. The destructive action of the X-rays on the skin is usually caused when low-vacuum tubes giving off rays of feeble penetrating power are employed; but these drawbacks can, for the most part, be avoided, without impairing the therapeutical value of the X-rays, by using a high-vacuum tube. Blacker remarks that "it does not seem unreasonable to suppose that rays may be isolated which may be found capable of destroying bacilli or acting upon various cells in different parts of the body;" and this would seem to warrant the hope that rays may be discovered which will be able to retard and destroy malignant growths, no matter in what part of the body they may occur, or whether the causation of cancer be parasitic or metabolic. All are in accord as to the healing power of the X-rays in rodent ulcer. As to the permanent value of the method, there seems to be more or less discord, though all agree that in a large proportion of cases the X-rays relieve pain.

Drugs are dismissed with little consideration. Chian turpentine, condurango, celandine, arsenic, morphine, and many others, have had their advocates.

The conclusions presented by Mr. Morris are as follows:

1. That the bactericidal bacterial treatment of malignant disease is not of the slightest use in carcinoma; that not one-half of the cases of spindle-celled sarcoma disappear under treatment with Coley's fluid; that in cases of sarcoma, other than the spindle-celled, Coley's fluid is not of value; that the treatment by Coley's fluid has many dangers, and should never be employed except in absolutely inoperable cases.

2. That Beaston's treatment is limited in its action to cases of mammary carcinoma, and the local and glandular recurrences after mammary carcinoma; and that even in these cases

only a small proportion are influenced by the treatment, while neither as a cure nor as a palliative can it be relied upon in any given case.

3. That rodent ulcer has in Finsen's light and in the X-rays its most successful treatment, so far as we at present know; and that this is true not only of cases otherwise inoperable, but also of operable cases, because of their excellent cosmetic results, and of their effect upon insidious and non-evident foci. There are, nevertheless, cases of rodent ulcer which resist the light, and others which resist the X-ray treatment, and some of these cases are successfully treated by excision and caustics.

4. That sarcoma, epithelioma, and other forms of carcinoma are best treated, whenever possible, by early excision; and that all forms of treatment hitherto tried in inoperable cancers of these kinds are uncertain and inconstant in their effects, and unreliable as to the durability of the results they produce. In the vast majority of cases they are quite without palliative influence of any kind, except possibly in removing pain.

5. That the boundary line between what are considered operable and inoperable cases needs revision from time to time; that the tendency to extend the limits of operable cases needs in some cases to be revised and restricted, and in others there may prove room for further extension.

6. That it is open to question whether some of the operations performed for relief or prolongation of life in inoperable cases of malignant disease should not be abandoned, and whether in other cases palliative operations ought not to be more often performed.

7. That investigations into both the cause and nature of cancer are of the first importance, as being more likely to ultimately lead to cure than any treatment at present known.

8. That, with few exceptions, the attempts to cure cancer by means other than early and free operations have been hitherto almost invariably futile.

The discussion was particularly interesting in that it showed that in Great Britain, as in America, much is hoped for from the use of the X-rays. Beaston, of Glasgow, stated that while we are ignorant of the *modus operandi*, there can be no doubt that the nodules of carcinoma disappear under the treatment. Bryant, of London, while cautioning his hearers against con-

sidering the treatment as completely curative, asserted that it led to the relief of pain and disappearance of the local manifestations. Brook, of Swansea, suggested that the nearer the cancer approached a rodent ulcer the more readily it should yield to the influence of the X-rays, and instanced a case of epithelioma scroti. Jessett, on the other hand, had in no case seen permanent benefit from the treatment, and a number of others expressed doubt as to the permanence of the cures.

THE INSTITUTE MEETING OF 1903.

A CIRCULAR letter just received from President-elect Joseph P. Cobb and Secretary Charles Gatchell informs us that the Executive Committee has decided that the Institute session of 1903 shall be held in the Back Bay district of the city of Boston, with the Hotel Somerset as headquarters. The session will be held the week of June 22 to 27, 1903.

We like decision and promptness. We believe them to be essential to success. In this case these qualities have been combined with accuracy of judgment in making the necessary arrangements for the entertainment of the Institute's membership. The Hotel Somerset will reserve 300 rooms for the occasion. Six other hotels are available for the overflow; for we must all admit that no one hotel is now sufficient to take charge of the Institute and its guests.

The Institute meetings will be held in the banquet-room of the Hotel Somerset, which will provide a most satisfactory auditorium. Six other rooms are available for sectional and committee meetings.

CONCERNING OURSELVES.

THE practice of throwing a bouquet at one's self is not to be commended; but inasmuch as we have refrained from doing so to date, we trust we will be pardoned for this departure from the time-honored policy of the *HAHNEMANNIAN MONTHLY*. The co-operation of the profession has enabled us

to present during the year 960 pages of good solid medical reading-matter. In addition, there is the index, which shows the value of the subjects treated. Let any of our readers look over the same, and note the many subjects in which he has had present or past interest. And the news! These pages for the year will number 178. This makes a grand total of 1138 pages. This record of quality and quantity we believe not to be surpassed by any monthly medical periodical published anywhere. This unseemly egotism may be softened by the statement that the HAHNEMANNIAN, for some time past, has been conducted by a staff of twenty-five physicians, all of whom have done good work in making the journal what it is.

To the members of the profession who have contributed to our pages we are especially indebted, for the contributors show the strength of a journal. We regret that a larger number has not seen fit to become our creditors in this respect.

We have had a recent demonstration of the popularity of the Clinic. On Thursday, November 13th, Dr. L. T. Ashcraft held a clinic in the Clinical Amphitheatre of the Hahnemann Hospital, before the Philadelphia County Society, his subject being the "Modern Treatment of Genito-Urinary Diseases." The capacious auditorium was crowded to the dome. Passageways were occupied as seats, and there was standing-room only. The lecturer talked for two hours, and held the undivided attention of his audience to the end. The roster of the Hahnemann Medical College provides for forty-eight class-room clinics and six clinical lectures weekly. This wealth of material we propose to avail ourselves of hereafter, and publish one clinic each month. Dr. Haines will widen the scope of the Retrospect by presenting, in addition to the usual abstracts of homœopathic literature, numerous reports of cases treated by *the* homœopathic remedy in his large clinic at the Hahnemann Hospital.

A CORRECTION.

ON page 819 of the November number appeared some remarks by Dr. T. H. Carmichael. The reporter turned in this discussion as part of the debate on Dr. Korndorfer's paper, when, as a matter of fact, it related to that of the succeeding essayist.

GLEANINGS.

SURGICAL HINTS.—In severe, crushing wounds of the hands or feet it is never advisable to remove at once any loose shreds of tissues or badly-mangled fingers and toes. Place the injured member in a large, wet dressing, after thoroughly cleaning it and stopping the bleeding. This will often enable the surgeon to save important parts that might at first have been sacrificed.

In employing cocaine for the relief of pain while operating upon mucous surfaces, as in the nose, or before applying escharotics to ulcers and chancreoids, it is often important to prolong the anæsthetic action as long as possible, without using too much of the drug. In such cases a solution of cocaine in an oily medium, such as equal parts of almond and petroleum oil, will take a good deal longer to act, but the effect will be very durable when once attained.

In cases of severe burns of the body, and particularly in children, the removal of the clothing, or of temporary dressing put on by the family, is often very painful. If they are first placed in a tub of warm water, to which a little salt has been added, the adherent fabrics may be more easily and painlessly removed. In many instances anæsthesia is to be employed. In adults suffering from bad burns morphine should be administered hypodermically, and it is well to remember that if the pain is great they can stand pretty large doses.

In enlarged glands due to acute septic infection there is no evidence that the use of tincture of iodine ever prevented suppuration. On the other hand, it renders the skin at first tougher and more unyielding, increasing in this way the pain due to tension, and later, as the superficial layers exfoliate, it produces a tender and absorbent surface, in which sepsis is more likely to occur. The use of iodine over swollen glands, like the employment of nitrate of silver to cauterize wounds, is one of the absurdities of medicine which still clings to us.

It requires a good deal of judgment to know the exact time when we must allow or encourage patients to get out of bed after operations. If they remain too long in bed, the muscles lose their activity, and hence complete recovery will be delayed. If they get up too early, injurious tension upon scar-tissue may result. Generally speaking, operations which may be followed by hernia demand the longest period of recumbency, while those operations in which the only post-operative dangers are hæmorrhage and sepsis only require rest in bed for a comparatively short time.

Herbert P. Leopold, M.D.

A CASE OF RUPTURED SPLEEN; SPLENECTOMY; RECOVERY.—Shield reports a very interesting case of a colonial trooper who was thrown from his horse on Coronation Day, August 9th. The horse rolled on him and then kicked him in the abdomen. On admission to the hospital he presented the

following symptoms: collapsed, semi-conscious, sweating freely, temperature 98° F. and the pulse 80 and weak; marked rigidity and tenderness all over left side, dullness on percussion over the region of the spleen, for an area of about four inches. A marked symptom was intense pain, the patient groaning and shrieking in agony. About three hours later the abdomen was opened externally to the left semilunaris, finding extensive hæmorrhage from a rupture and extreme laceration across the hilum of the spleen; after ligating the pedicle, the spleen was removed and the patient infused with two pints of normal saline solution, and one pint of the same solution was given per rectum. On August 19th a blood examination was made, with the following results: white corpuscles, 21,000 per cubic millimetre; polymorphonuclear, 79.5 per cent.; eosinophile, 1.5 per cent.; hyaline, 5 per cent.; lymphocytes, 10 per cent.; hæmoglobin, 90 per cent.

On Sept. 22d the patient was given solid food for the first time. Examination of blood gave the following results: red corpuscles, 5,083,000, showing little signs of degeneration. October 4th, the red corpuscles numbered 4,962,500 and the white corpuscles 16,000 per cubic millimetre; hæmoglobin, 82.5 per cent.; polymorphonuclear, 74 per cent.; eosinophile, 1-3 per cent.; hyaline, 8 per cent.; lymphocytes, 15.3 per cent. On October 20th the patient is rapidly gaining in weight and feeling strong.—*The Lancet*.

Herbert P. Leopold, M.D.

OZONE IN CHRONIC MIDDLE-EAR DEAFNESS.—The form of deafness to which Stokes, of London, refers is popularly known as "throat deafness," and generally believed to be due to stenosis of the Eustachian tube. The symptoms are progressive deafness with tinnitus, the tympanic membrane is retracted, and usually opaque. This is the most common and intractable, and it is no exaggeration to describe it as the opprobrium of otology. The ozone was generated by means of an electric current acting on a Ruhmkorff's coil, to which the ozonizing tube was attached and the ozone pumped into the middle ear through an Eustachian catheter, for about three minutes, from twice to four times a week. The results were very gratifying; in fact, the results in some of the cases reported by him were remarkable. The tinnitus disappeared after a few applications. It is reasonable to suppose that if the ozone had been used every day the results would have been better.—*The Lancet*.

Herbert P. Leopold, M.D.

A CASE OF TRAUMATIC RUPTURE OF THE SPLEEN; REMOVAL, FOLLOWED BY EMPYEMA AND RECOVERY.—Beaumont and Houseman, London, cite a very unusual case which was brought to the hospital—that of a youth with the history of having fallen from a wagon, one wheel passing over his body. He was suffering great pain in the loin; he also had a bruise over the ninth and tenth ribs in the posterior axillary line. At the time of admission his temperature was 97.6° F., respiration 24, and pulse 100. A few hours after examination he became very restless, with distention of the abdomen and loss of liver dullness. Under an anæsthetic a distinctly loose body was felt, which later turned out to be a portion of the spleen. A free incision was made in the median line, and on opening the peritoneal cavity it was found full of blood-clots, while the welling up of blood showed that hæmorrhage was still taking place. On further examination the spleen was found to be in two pieces, and, the hæmorrhage being controlled by holding the vessels

with the fingers, it was drawn to the surface and the pedicle clamped, this latter was tied, and the spleen removed. The usual abdominal sterilization was then carried out, and the abdomen closed. The patient was in a very collapsed condition, the pulse having risen to 160, but fell the next morning to 120. He remained in a practically unconscious condition until the third day, when the temperature suddenly rose to 105° F., accompanied by delirium and involuntary discharge of urine and fæces. On examination of the wound it was found to be in a healthy condition. On the sixth day from the operation, fluid was detected effused at the base of the left lung. Aspiration was performed, with the removal of six ounces of decomposed blood. Deciding that the blood had come through the diaphragm, an exploration of the sub-diaphragmatic region was made by resecting the lower ribs. No pus being found, the opening was closed. The conclusion was then reached that septicæmia was the cause of the high temperature, and, on blood-examination, streptococci in large numbers were found. Ninety c.c. of anti-streptococcic serum were injected, but with little effect on the temperature. Four hours later a large pleural effusion was recognized on the left side. The pleural cavity was tapped, withdrawing two pints of blood-stained fluid, but sweet. The injections were continued for four days, 330 c.c. having been given in that time. On the fifth day of injections the temperature fell to normal, and the patient for the first time became conscious. A rise in temperature caused an examination to be made on the sixteenth day subsequent to the original operation, which revealed a localized empyema in the left chest, about the angle of the scapula. Subsequently considerable portions of the seventh and eighth ribs were resected, when there was a free discharge of pus for several days, but the temperature still remaining high, 104° to 105° F., daily. The use of pure oxygen was tried, by passing a tube into the pleural cavity, with excellent results, the temperature dropping and the discharge practically ceasing; also, general repair of all his wounds commenced. Even up to the present date, while the patient is enjoying as good health as he did before the accident, his pulse does not fall below 112. Since the removal of the spleen there has been a marked general enlargement of the lymphatic glands, associated with anæmia. The patient is now doing light gardening.—*The Lancet*.

Bernard E. Bigler, M.D.

CHOLECYSTECTOMY VERSUS REMOVAL OF THE MUCOUS MEMBRANE OF THE GALL-BLADDER.—Emil Ries, M.D., of Chicago, strongly advocates the removal of the gall-bladder and cystic duct in cases of calculi, instead of May's method of removing the mucous membrane. He claims the removal of the gall-bladder is, as a rule, neither a difficult nor a dangerous operation. His method is to tie off the cystic duct close to the common duct, to remove the gall-bladder, to close the cystic duct by inversion of its walls, then to suture a piece of omentum over the stump, a small gauze pack down to the stump being left in the wound. He argues that the operation of stripping the mucous membrane is best adapted for a secondary operation, that is to say where a cholecystotomy has been performed without the desired results. The objection to the removal of the mucous membrane is based upon its histological structure. Examination shows that not only do the glandular cells penetrate the mucous membrane, but that they are imbedded in the connective tissue of the subserous portion, thus emphasizing the fact that little good can be obtained by

the removal of the mucous membrane, for it does totally destroy the secreting power of the gall-bladder, and does not, therefore, prohibit gall-stone formation.—*Annals of Surgery*.

Bernard E. Bigler, M.D.

DOUBLE POTT'S DISEASE.—A very interesting case, on account of its rare occurrence, is cited by Taylor, of Baltimore. On examination of a boy seven years old, he was found to be suffering from double Pott's disease, the foci of tuberculous degeneration being distinctly isolated, one focus involving the fifth, sixth and seventh dorsal vertebræ; the other, the first, second and third lumbar vertebræ. The family history was good as to tubercular disease; also the personal history, pertussis being the only infantile disease from which he had ever suffered. Three years prior to the examination he fell from a straw stack, with seemingly no bad results, until eight months afterward, when he complained of pain in the abdomen, which was evidently the commencement of the lumbar involvement. He had the usual symptoms arising from the efforts to protect and support the spine, lordosis while standing or walking, and some bladder irritation. Five months before his examination the dorsal involvement appeared. At the present time there is psoas contraction in the left leg, and on deep palpation in the iliac fossa a cold abscess the size of a lemon can be felt. The treatment in this case has been continued recumbency on a board covered with a blanket, except an hour or two in the morning and afternoon, when he wears the Taylor back-brace, head-support and apron. Two good radiographs are appended to show the points involved.—*American Medicine*.

Bernard E. Bigler, M.D.

A STUDY OF UTERINE FIBROMYOMATA, WITH ESPECIAL REFERENCE TO THEIR DEGENERATIONS AND COMPLICATIONS.—Frederick states that the degenerations and complications of fibromyomata of the uterus have not been given the prominence that they merit. From a histological standpoint they receive full consideration, but the remote effects are not dealt with as they should be. The ideas gained from past experience as to benignancy must be modified. Another fallacy is the statement that fibroids of the uterus would almost certainly undergo atrophy and be absorbed at or after the menopause. In such cases the majority follow out the opposite course, and develop at a later period discomfort from pressure, and hæmorrhage from degenerative changes which lead the family physician to send his patient to the specialist. The complications are enumerated as follows: cystic, calcareous and myxomatous degeneration of the tumor; suppuration or hæmatoma of the tumor; sarcomatous degeneration; carcinoma of the endometrium and body of the uterus; necrosis of the tumor; fibromyitis, etc.; associated complicating diseases of the appendages, *i.e.*, salpingitis, pyosalpinx, ovarian cysts and ovarian abscess. To these local complications may be added those of a systemic nature; as, for instance, the remote effects of long-continued hæmorrhages, the effects of long-standing local pressure; also, the results of an increase in the intra-abdominal pressure.

Furthermore, the ill results obtained through general nutrition, and the circulatory, digestive and nervous systems. The complications are classified into two groups: First, those which would probably lead to a fatal termination. Second, those which would threaten the life of the patient or lead to chronic invalidism. In the first group are placed sarcoma, adeno-carcinoma,

abscess formation, extensive hæmatoma, necrosis, twisted pedicle, and cystic degeneration. Of the second group, ventral and umbilical hernias, universal adhesions, inter-ligamentous development, etc.

The impossibility of recognizing what percentage of patients afflicted with fibroid tumors of the uterus have died in the past, before aseptic abdominal surgery came to their relief, is well recognized. This can never be known. A conservative estimate would be one-third to one-half fatalities.

In the listing of a table of ages, noting time of operation, it is shown that the period approaching the menopause brought forth symptoms that required the greatest per cent. of operations. Of the 58 cases listed among the operated, 39 were over 45 years of age.

Bishop's 37 fatal cases are quoted (without operation). The author observed two such fatalities, both patients being too far advanced to justify operation. The mortality from operation is reported as from 2 to 10 per cent.; without operation, from 30 to 50 per cent. The writer's observation is noted to the effect that those who have recovered from the operation are in good physical condition, while a very large proportion of those not operated upon are in a state of chronic invalidism. Statistics all point to the advisability of early operation. The possibility of leaving a wrecked body after operation, when the patient has previously been a confirmed invalid, should never be lost sight of.

There may be exceptions to the necessity of operating on all fibroids. In the author's experience, small, hard, sub-peritoneal nodules in women over 40 years of age are not liable to grow, or at least not rapidly. With this possible exception, most fibroids give rise to various symptoms, and should be removed. —*American Gynecology*, Sept., 1902.

Theodore L. Chase, M.D.

PARATYPHOID FEVER.—(Johnston.)—The cases reported were in the medical wards of the Johns Hopkins Hospital, in Baltimore. In 2 of the cases a paratyphoid bacillus was isolated in pure culture from the blood. After a very careful analysis of the cases reported the writer deduces the following:

(a) There is a type of disease due to the infection of the *paratyphoid bacillus* which in all its variations presents a clinical picture identical with that frequently produced by infection with the *bacillus typhosus*.

(b) Diarrhœa and the termination of the fever by crisis are far more frequent in occurrence than in typhoid fever.

(c) Myositis and purulent arthritis, rare complications in typhoid, have been recorded.

(d) Though the disease may be severe it is usually mild, and fatal cases are rare.

(e) Absence of intestinal ulceration may be a distinctive feature of the disease.

(f) The disease, though widespread and occurring in localities where typhoid fever is present, is comparatively rare.

(g) Every instance of negative Widal is not due to infection with the paratyphoid bacillus.—*The American Journal of the Medical Sciences*, August, 1902.

William F. Baker, A.M., M.D.

PROSTATIC GONOCOCCAL AUTO-REINFECTION OF THE URETHRA.—(Townsend.)—For the convenience of consideration, these recrudescences may be

classified into (1) those which occur before convalescence is established; and (2) those which occur some time after the cessation of all symptoms. Early and prompt measures should be taken to avoid this complication, and if infection of the prostate should take place, then it should be prevented from becoming follicular in character; for with the invasion of the follicles the tendency is to become chronic. Another interesting feature of these conditions is the fact that they can be differentiated from acute infections.

As to treatment, it may be said to have for its object the evacuation of the diseased follicles and the regeneration of them. One of the best means to this end is prostatic massage. This should be practiced daily, followed immediately by thorough irrigation of both portions of the urethra, to prevent recurrent acute urethritis. We might say, here, that omission of the irrigation is permissible for diagnostic purposes. The management of the urethritis does not materially differ from that of acute gonorrhœa, except that intravesical irrigation may be practiced from the beginning of the treatment.

When a stenotic meatus, stricture, or urethral infiltration exists, instrumental treatment may be instituted between the massages, thereby gaining time.

The selection of the irrigating fluid depends upon the microscopic findings, silver preparations being preferable. When the gonococci disappear, other bacteria remaining—*e.g.*, colon bacilli, strepto- or staphylococci, solutions of corrosive sublimate are indicated; where no bacteria are demonstrable, astringents.

It is well to warn the patient of possible future reinfection, and in any cases it is well to reserve opinion as to the possible duration.—*The American Journal of the Medical Sciences*.

W. F. Baker, A.M., M.D.

PATHOGENESIS OF THE POST-HÆMORRHAGIC AMAUROSES.—Assicot reports the following cases of this condition: The first was that of a 40-year-old female, whose previous medical history was negative. For two years past she had suffered from headache, vertigo, and emesis. A profuse metrorrhagia, lasting six days, developed, followed two days later by absolute and permanent blindness, and by a complete subsidence of all other symptoms. Five weeks after this the fundus of each eye showed the typical changes of post-neuritic atrophy.

The second case was in a 44-year-old married woman, who developed a profuse metrorrhagia, lasting eight days. Three weeks later complete and permanent blindness rapidly ensued. At that time there was discoloration of the optic papilla, with filiform retinal arteries and slight distention of the corresponding veins. The condition at the time of writing, three months later, was that of complete white atrophy of the optic nerves.

Amaurosis following hæmorrhage, the author says, occurs most generally in men, and between the ages of 35 and 40 years. It most frequently follows the hæmatemesis of gastric ulcer. Among women, amaurosis is rare after normal labor, and usually follows an abortion or appears after metrorrhagia at the time of the menopause. The fundus lesions are included under four classes: First, no change, atrophy later; second, rapid appearance of the atrophy; third, hæmorrhagic neuro-retinitis as found in albuminuria; fourth, papillo-retinitis, terminating in marked post-neuritic atrophy. Owing to the diverse appearances, the pathogenesis cannot be limited to a single cause.

Vascular spasm, endarteritis, lymph-taxis and infection have all been advanced as the factors in their production. It is probable, he says, that the cause is complex, including all of the above-mentioned elements.—Dr. Assicot, Paris.—*Archives d' Ophthalmologie*.

William Spencer, M.D.

THE PROGNOSIS OF CERTAIN GENERAL DISEASES ACCORDING TO SOME OF THEIR OCULAR MANIFESTATIONS.—De Micas briefly enumerates a few of the ocular complications of general disease. In most instances the presence of ocular changes is against a favorable prognosis.

In pneumonia, however, pupillary inequality with mydriasis more marked on the side of the lesion, and appearing early and persisting, is a good symptom.—Dr. De Micas, Toulouse.—*La Clinique Ophthalmol.*

William Spencer, M.D.

INJECTION OF AIR INTO THE ANTERIOR CHAMBER FOR TUBERCULOSIS OF THE IRIS AND OF THE CORNEA.—A healthy-looking lady, 22 years old, with hereditary tubercular taint, had an acute iritis, which improved with rest and hot compresses, but soon became worse, and complicated with cyclitis.

The inunction treatment had no effect. Eight weeks later, while the hydragryrum treatment was still being carried out, a number of small, dense tumors appeared in the nasal quadrant of the iris. From their position, their rapid development, and their yellowish color, a diagnosis of tubercle was made. An iridectomy including a part of the growth was made. The anterior chamber of a rabbit's eye was inoculated with this, but with negative results. The tubercle kept on growing, so that the eye was considered lost. At this stage Koster introduced into the anterior chamber a Pravaz syringe half-filled with sterilized air. Drawing off the aqueous, he filled the chamber with the sterilized air without removing the canula. The effect was very beneficial, and the air absorbed quite rapidly.

This procedure was repeated three times, after which the eye appeared cured. During the next few weeks the inflammatory exudate had absorbed, and the media cleared, leaving the patient a vision of $\frac{6}{18}$. After the correction of the wound astigmatism the patient had vision of $\frac{6}{12}$. A number of cases treated, in which the stereotyped methods, such as inunctions, iodoform, etc., were without beneficial results, were so rapidly cured by the injection of sterilized air that he advises the trial of it in all cases of tuberculosis of the cornea, iris, and choroid. They should be repeated frequently.—Prof. W. Koster.—*Annals of Ophthalmology*.

William Spencer, M.D.

ANGIOSARCOMA OF THE RETINA.—Feillais believes that the classic phrase "glioma is the only neoplasm to be observed in the retina" is not any longer satisfactory. He says that the observation of Greeff with the Golgi-Cagal method forces us to believe that retinal glioma is much less frequent than retinal sarcoma. The history of a case reported by him is the usual one seen in a case of malignant ocular tumor of childhood, enucleation being followed by speedy death.

The enucleated eye was hardened in formaline. The growth filled the vitreous chamber and presented a marbled aspect throughout. The tumor-mass was composed of perivascular tubes formed by round cells at the periphery and epithelial cells in the centre, these tubes being separated by zones of

more or less marked degeneration. The part of the neoplasm developing at the expense of the choroid contained larger and more deeply staining cells held in the meshes of an abundant reticulum. The vessels were more numerous in the portion that was situated within the pigment epithelium, and had the appearance of lacunæ, some of which possess very thin walls. Interstitial hæmorrhages were frequently seen.—Dr. Feillais, Nantes.—*Annals d'Oculistique*.

William Spencer, M.D.

CLINICAL REPORT OF THE ROTUNDA LYING-IN HOSPITAL.—(Purefoy, Lloyd and Carton.)—There were three cases of chorea complicating labor, one of which ended in mania. In the other two morphine and bromides were given without success, and hyoscin was used with good effect. The chorea ceased soon after labor in seven cases of pure mania. Hyoscin was used subcutaneously with good success.

In one case the patient had a left-sided ovarian cyst removed four months previously, and a varix in the left broad ligament resulted. Secondary hæmorrhage made it necessary to re-open the abdomen. The patient has since then given birth repeatedly, and each time, as in the present instance, she has had a hæmatoma in the left broad ligament. The hæmatoma rapidly diminished in size during the puerperal period.

There was one case of triplets, each child weighing, respectively, four, four, and three and one-half pounds. They lived six days; all males; all head presentations, with one placenta and hydramnios in second sac.

There were eleven labors complicated by fibroids. For the most part, the women were in the twenties, and labors were normal, without much hæmorrhage, though weak pains were not uncommon.

There was one case of a primipara, 26 years old, with a conjugate diameter of 7.25 cm. Cæsarean section was performed in consequence of threatening rupture of the uterus, with good results for mother and child.

There were two cases of rupture of the uterus. In the first case, a penetrating rupture, laparotomy was performed and the uterus was removed; the patient died on the third day. The second case, a non-penetrating rupture, was successfully treated by tamponing with iodoform gauze.

Out of 1560 cases delivered in the hospital, six died; one was due to hyperemesis and Bright's disease, one from acute miliary tuberculosis, one from embolism of the lungs, one from disease of the kidneys, and one from rupture of the uterus.—*Dublin Journal of Medical Science*.

George R. Southwick, M.D.

A NEW TREATMENT FOR HYPEREMESIS.—The writer is of the opinion that the uncontrollable vomiting of pregnant patients depends more or less upon the general affection of the blood by toxines, and communicates a series of cases treated successfully by copious salt solution to dilute and eliminate the toxines in the blood.

Nourishment by the stomach is entirely abstained from for the time being. Three to four liters of salt solution, and sometimes a few drops of laudanum, are added, and injected daily by rectum in doses of 300 c.c. After the tenth or twelfth day, food can be taken in small quantities by the mouth. If necessary, salt solution can be injected subcutaneously.—*Lyon Med.*, Feb. 2, 1902.

George R. Southwick, M.D.

THE INDICATIONS FOR THE INDUCTION OF LABOR.—(Hofmiev.)—In nephritis, as an indication for the induction of labor, we must differentiate between chronic nephritis and the nephritis of pregnancy. In chronic nephritis pregnancy is to be interrupted if, in spite of treatment, the secondary signs of the disease do not improve, but grow worse. In nephritis of pregnancy, special attention must be given to the danger of eclampsia, and the operation is indicated if the symptoms progressively increase in spite of dietetic treatment.

Pinard divides the cases requiring operation into two groups. In the first group may be mentioned uterine hæmorrhage, with a pulse of over 100 per minute: hydramnios, moles, toxæmia of pregnancy, such as uncontrollable vomiting, albuminuria, eclampsia and toxic neuritis.

He puts in the second group diseases of the circulation, diseases of the kidneys when the total daily secretion is less than 800 to 1000 c.c., pyelonephritis with severe symptoms, and diseases of the lungs, such as tuberculosis, which, in itself, is not always to be regarded as an indication.

Rein, of St. Petersburg, performed the operation in Kiew 37 times in 2690 cases of pregnancy. The indications were contracted pelvis, extra-uterine pregnancy, cicatricial atresia of the vagina, habitual death of the fœtus, septic endometritis, nephritis, eclampsia and heart disease.

Schauta, of Vienna, based his remarks on 4000 cases. Induction of labor is necessary in severe forms of polyneuritis gravidarum to save the mother's life. It is often necessary in cases of chorea complicating pregnancy, as in severe cases where it is impossible to maintain nutrition, and to avoid termination of the chorea in mania.

Premature labor is necessary with some brain tumors which are fatal, and the operation must be performed after the beginning of the loss of consciousness.

In hemiplegia, pregnancy may be interrupted in the interest of the child at the time of the mother's death. Psychoses only require the interruption of pregnancy when the patient is much reduced, and there is danger of suicide. Epilepsy very rarely requires interruption of pregnancy. Hysteria is apt to be aggravated rather than improved by the operation. Diseases of the eyes, with the exception of eclampsia and albuminuric retinitis, rarely indicate the termination of pregnancy.

The operation does not benefit advanced cases of pulmonary tuberculosis, but it may be advisable to perform the operation during the first month, especially for tuberculosis of the larynx. Premature labor is indicated in military tuberculosis as soon as the child is viable. Bronchitis, emphysema and asthma do not indicate the induction of premature labor. About one-seventh of all the cases of heart disease only during pregnancy are recognized. Premature labor takes place spontaneously in about 20 per cent. of the cases. The mortality of the children is 25 per cent. With proper treatment, 95 per cent. of the patients pass through the strain of labor without serious consequences.

Tuberculosis and chronic nephritis are the most unfavorable complications. Mitral stenosis is the most dangerous of the heart diseases.

It is seldom that heart disease has a bad effect on pregnancy; labor is more dangerous for the heart than pregnancy. If there is complete compensation, the interruption of pregnancy is only indicated if the life of the mother has been seriously endangered by it in a previous pregnancy.

In mitral stenosis, pregnancy is to be interrupted immediately with the least sign of failure of compensation. In ordinary non-compensated cases of heart disease, internal medication is to be faithfully tried first.

Complications of chronic nephritis and tuberculosis require more active measures. The operation must be performed as soon as pus is found, without reference to pregnancy. Severe symptoms of icterus gravis, such as high fever, petechiæ, diminution of the liver, and especially nervous symptoms, require the immediate interruption of pregnancy.

Cholecystectomy is the operation of preference for gall-stones complicating pregnancy.

The induction of premature labor for hyperemesis is occasionally necessary as a last resort. It is also necessary for albuminuria and nephritis if improvement does not follow a strict milk diet. In eclampsia of lesser degree morphine and milk diet should be first tried.

In amaurosis and retinitis, premature labor should be induced at once. Diabetes gravidarum has a bad prognosis: one-fourth of the mothers die, and most of the children perish.

Pregnancy should be interrupted in the earlier months, and in the second half if there is a high percentage of sugar: otherwise, the operation may be delayed until the child is viable.—*Centralblatt für Gynakologie*.

George R. Southwick, M.D.

TWO CASES OF LABOR COMPLICATED BY FIBROIDS OF THE CERVIX.—(Mahlem.)—The first labor five years previously was very protracted. The midwife noticed some peculiarities that she could not explain. There was nothing of special importance during the second pregnancy. The midwife believed that twins were present, and for this reason sent for the writer.

The child occupied the usual position on the left side, and on internal examination, the pelvis was found to be filled by a mass which the writer believed to be the head, and the sutures and fontanelles were very indistinct.

After six hours' delay, during which there were very few pains, the forceps were applied. These slipped, and a more careful examination disclosed the presence of a fibroid tumor. This was then enucleated, which was rather tedious and attended by some loss of blood. The tumor was extracted by the obstetric forceps after enucleating it from the capsule, and labor was terminated by the forceps.

The placenta was expelled spontaneously, the loss of blood was trifling, and the puerperium uneventful. The child was large and alive. The tumor was a hard fibroid about the form and size of a child's head.

CASE II.—The patient was a primipara who passed through pregnancy without any complications. She was seen after having been in labor all day, and the midwife believed that the head was present in the vulva. The patient at that time was much reduced, the pains weak and spasmodic. Morphine was given subcutaneously and the patient slept through six hours. A fibroid filling the small pelvis was found on examination. This was enucleated with ease, and only moderate hæmorrhage resulted. A living child was extracted by the forceps, and the puerperium was uneventful.—*Centralblatt für Gynakologie*, No. 34, 1902.

George R. Southwick, M.D.

THE PERMANENT RESULTS OF THE OPERATIVE TREATMENT OF UTERINE FIBROIDS.—(Sauer.)—The writer reports the results of 104 myoma operations, 62 laparotomies, 21 total extirpations and 2 castrations.

Among the laparotomies there was one total extirpation; all the others were supravaginal amputations. The operations gave good results.

The tumor shrinks as a rule after castration; climacteric disturbances seldom follow, whether the uterus is removed or either one or both ovaries.

Psychical disturbances do not follow as a consequence of the operation.—*Ibid.*

George R. Southwick, M.D.

POISONING BY MEAT AND TYPHOID FEVER.—Drs. E. Levy and E. Jakobs-thal think that they have traced a connection between poisoning by meat and typhoid fever. Under the name of meat-poisoning two groups of symptoms have been described. First, there is the nervous form, where the patient suffers from a dry mouth and throat, hoarseness, dilation of the pupils, ptosis, etc., a condition which was formerly called "sausage poisoning" and which is dependent on a specific microbe, the bacterium botulinus (van Ermengen). Then there is the better-known gastro-intestinal variety which runs its course with fever, gastro-intestinal symptoms, nephritis, and often with cutaneous exanthems. It appears after eating of the meat of animals which have suffered from septic diseases, as sepsis, pyæmia or puerperal fever, or after having partaken of spoiled meat, and it is due to bacteria of the coli-group, and especially to those standing between the bacillus of typhoid fever and the bacterium coli commune; rarely is the bacillus proteus the cause.

Some epidemics of meat-poisoning pursue their course under a clinical picture which wholly covers that of typhoid, and neither clinically nor pathologico-anatomically can they be differentiated from that disease. Some of these epidemics have become well known as those of Birmensdorf (1879), Wuerenlos (1880), Andelfingen (1839) and Kloten (1879). But only the last two, which appeared after having eaten of veal, may be regarded as determined. At Kloten two calves were slaughtered and served up at a village festival. These animals had seemed ill soon after being born, and were killed seven days after birth. The disease here had all the peculiarities of an acute infectious affection, for those ill infected others who had not eaten of the meat. While there is no doubt as to the connection between the eating of the meat and the disease, there is a difference of opinion as to whether these epidemics were actually typhoid fever. The chief objection has been that cattle cannot contract typhoid, but laboratory investigations have shown that the same germ in different animals may give rise to quite different diseases.

The writers assert that they have found the missing link between these cases of poisoning by meat and typhoid fever. A cow was slaughtered in Strassburg, March, 1901, in whose spleen a large abscess was found, as well as several small ones in the liver; otherwise nothing abnormal could be made out. A pure culture of a bacterium of the coli-typhoid group was detected, but none in the flesh itself. This bacterium by cultivation, experiments on animals and in other ways, was identical with that of typhoid. It also yielded Widal's reaction. Hence if the meat had been eaten insufficiently cooked it might have communicated the disease to man.—*Hospitalstidende*, No. 40, 1902.

Frank H. Pritchard, M.D.

THE INJURIOUS EFFECTS OF THE SALICYLATES ON THE URINARY PASSAGES AND KIDNEYS.—Dr. H. Luethje, privat-docent of internal medicine and

chief physician of the medical clinic of Greifswald, Germany, having noticed that at times various writers had called attention to the occasional injurious effects of the salicylic acid and its derivatives on producing nephritis, from experiments has concluded that they are able to cause such complications in all patients taking the drugs.

He had noted a certain degree of albuminuria after the administration of the salicylate of soda which disappeared after leaving off the remedy, reappear after taking it again. Hence he made a series of investigations on thirty-three persons, suffering from rheumatic affections with normal kidneys. He then gave them from three to five gms. of the salicylates, in three doses, at intervals of an hour, or salol, in three doses of one gm. each. The urine was examined often both during and after taking the drugs. In none of these thirty-three subjects was the urine free from abnormal urinary constituents. Albuminuria was often noted with white- and red-blood corpuscles; besides, there were epithelial formations from all parts of the urinary passages. Granular and hyaline casts were more or less constant. There were, besides, a greater or less quantity of crystals of the oxalate of lime. The greater the amount of the drug and the oftener the dose taken, the more pronounced were the symptoms of renal irritation. Hence the condition under investigation was a true nephritis, which persisted a long time after the medicine had been left off and when no trace of the remedy could be detected in the urine. Indeed, the characteristic reaction of this drug, a blue coloration of the urine after adding the perchloride of iron, was only noticeable from two to four days after discontinuing the treatment while the abnormal urinary constituents persisted on an average about fifteen days, afterwards. Besides these renal elements certain vesical formations were discovered, and cystoscopic examination revealed the mucous membrane of the bladder intensely irritated. The ureters themselves participated in the inflammatory process, if one could judge from the ease with which they bled on being catheterized. Therefore, he would restrict these preparations to acute rheumatic fever, not exceeding four or five gms. a day, nor would he continue the treatment longer than four days.—*La Semaine Medicale*, No. 41, 1902.

Frank H. Pritchard, M.D.

A CASE OF RUPTURE OF A CARDIAC VALVE FROM SUDDEN OVEREXERCITION.—Drs. Borquin and de Quervain report the interesting case of a drayman of thirty-five years who, in attempting to stop a heavy cask containing six hundred litres, which was rolling down an incline, suddenly felt a peculiar sensation like a blow from a whip in his chest. He bled at once from his nose, and left off his work, as he felt weak and ill. The following days he suffered from malaise, cough, and expectorated mucus mixed with blood. His pulse was persistently quite rapid, and three weeks after the accident a systolic murmur was detected at the mitral valve. Pulse, 110-120; temperature in the evening, 38° C. Later, he complained of pains in his chest, stomach, loins, and especially in the region of the spleen, and vomited bile; his urine contained albumin. He suffered from dizziness, pains in his legs, and, seven weeks after the accident, he died of a left-sided hemiplegia. The necropsy revealed the anterior leaflet of the mitral valve to be the seat of an irregular thickening, with a nodular surface which crumbled when touched. The heart-muscle was slightly degenerated. There were infarcts in the spleen

and in the kidneys. The affected valve was found inflamed from a relatively recent endocarditis, with colonies of staphylococci. The patient had enjoyed "excellent health" before the accident, and the disease was ascribed to the traumatism. The distinct localization was hardly characteristic of an old endocarditis, and though no changes peculiar to a rupture of a valve were found, this was thought impossible on account of secondary inflammatory changes or alterations.—*Centralblatt fuer Chirurgie*, No. 41, 1902.

Frank H. Pritchard, M.D.

PUPILLARY DIFFERENCE AND ITS DIAGNOSTIC IMPORTANCE.—Dr. Schaudman, of Helsingfors, Finland, at the fourth meeting of the Northern Congress for Internal Medicine, asserted that of late years we have come to the conclusion that a difference in the size of the pupils has not been found to have the great diagnostic importance which was earlier attributed to it, and he is inclined to lay stress on it only when it is associated with limited or abolished reaction to light. The writers, from their researches, have found a difference in the size of the pupils in normal persons of 1-2 per cent., and in those with internal diseases of 18-46 per cent. In some it was constant, in others only transient. The reaction to light was nearly always preserved, except in four patients, who probably had some organic disease. Out of 1186 polyclinic patients, 331, or 27.9 per cent., presented a difference of pupillary size; and out of 723 hospital patients 273, or 37.8 per cent., offered the same condition. The frequency was the same in both males and females; the left pupil was oftener enlarged than the right (other writers have noted the same). In 4 per cent. of these patients there was "jumping mydriasis," or "jumping pupils," i.e., first the one and then the other pupil would dilate. This sign has long been regarded as of evil omen,—a view which the writers cannot endorse. They would rather hold with Koenig that it was without importance if the reaction to light be preserved, and if there be no associated sign of a nerve- or brain-disease. A difference in the size of the pupils is much more often noted in neuroses than in other diseases, and if it cannot be directly attributed to a nervous disease, or some other affection, it is merely a sign of a constitutional anomaly, an asthenic diathesis.—*Hospitalstidende*, No. 39, 1902.

Frank H. Pritchard, M.D.

EXTRA-UTERINE PREGNANCY, MISTAKEN FOR APPENDICITIS.—Dr. Legueu, of Paris, at a recent meeting of the Surgical Society of that city, in referring to three cases reported of extra-uterine pregnancy, reported at the former session of the society, where one was mistaken for an appendicitis, said that he had twice made the same mistake himself. In a woman of 48 years appendicitis was suspected and diagnosed, on account of the elevation of temperature and the greater degree of pain in the right iliac fossa. An operation revealed the left tube to be the seat of an extra-uterine pregnancy, which had ruptured. In another case, when he was at the Charité Hospital, he committed the same error. In both cases he was surprised at the absence of muscular resistance over the right iliac fossa.—*La Semaine Medicale*, No. 42, 1902.

Frank H. Pritchard, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY O. S. HAINES, M.D.,
with the collaboration in German literature of C. Sigmund Raue, M.D.

SOME THERAPEUTIC HINTS IN PEDIATRIC PRACTICE.—In many instances the identical indications for a remedy in an adult can be applied to the sick child, the only difference being that in the latter said indications must be deduced from a careful observation of the patient, while in the former they can be conveyed to the physician by word of mouth. It seems hard enough, in many instances, to obtain sufficient symptoms for a prescription by rigid and painstaking cross-examination of the patient, but it is even more trying when one is obliged to guess at the various localities affected, the sensations experienced, and the aggravations and ameliorations likely to exist. And still this is possible; often quite easy.

Perhaps no better condition exists in which this deductive mode of prescribing can be illustrated than in broncho-pneumonia. Here it is reasonable to suppose that when the infant cries every time it is obliged to cough, and even makes plain efforts to suppress the cough, *that the cough is painful*, and we immediately think of such remedies as *arnica*, *bryonia*, and *squilla*. *Arnica* is hardly likely to prove of use unless the chest has become sore from violent coughing paroxysms, and it is more suitable to cases of whooping-cough than to pneumonia. *Bryonia* may be excluded when pleurisy is not associated. *Squilla* is the remedy, *par excellence*, in broncho-pneumonia with tantalizing, painful cough, abundant secretion, and impaired cutaneous circulation.

How shall we arrive at a knowledge of the indications for phosphorus? The writer was recently impressed with the wonderful efficacy of this drug in a serious case of broncho-pneumonia in an infant 4 months old, referred to him by Dr. Haines. Tartar emetic had been given, but there was not enough secretion, not the characteristic rattling of mucus in the large bronchial tubes, nor was there the characteristic cyanosis of this remedy. Still, the respirations were very rapid, above 80 per minute, and dyspnoea was very apparent. Besides, the cough was ineffectual, and at times decidedly hoarse.

Let us but recall the indications for phosphorus in the adult. The keynote is a tightness across the chest, making it difficult to breathe, and the patient wears himself out with short, rapid respirations. Again, the vascular engorgement of the lungs and the overfilling of the right heart are the prominent physical conditions—they far exceed in importance the amount of consolidation in the lungs or the abundance of secretion in the bronchi; and, furthermore, there is pronounced toxæmia, the patient is prostrated, drowsy,

and apathetic. Does this condition not exactly apply to the above case in question? Here we had an infant with an engorged lung, harassing cough, dyspnœa and tachypnœa, drowsy and prostrated, and phosphorus was prescribed with the most happy results. This kind of prescribing *always gives results*, and, besides, it is more rational and more interesting than the mere watching of symptoms.

AMBRA GRISEA.—I have thought that this remedy benefited the sleeplessness that is so often complained of by women. They worry during the day and cannot get to sleep at night. One or two doses of ambra grisea 3 permits them to fall asleep. At least that is the way it has happened in my experience. The ambra patient can seldom tell why sleep is prevented. They tell us that there seems to be no reason why they cannot fall asleep, which is equivalent to saying that the cause is generally in the nervous system. Sometimes coldness and a nervous twitching may be present, which would further confirm us in our opinion that it is a nervous wakefulness rather than an insomnia produced by physical ailments. And, indeed, the ambra is a great remedy when this "nervousness" is at the bottom of the physical complaints of the patient,—when a woman gets nervous, or says she gets nervous, and has to eructate great quantities of gas; when she gets in the same state of mind and has a great accumulation of gas in the intestines, which distends the abdominal walls; or when, from some influence upon the nervous system, she has a constant spasmodic cough, which is aggravated in the presence of company or whenever she attempts to talk or to entertain. Again, such patients are apt to have palpitation, during which they feel so nervous that the heart-beats are perceptible all over the body. And so we might mention many things that ambra relieves, when at the bottom of all the trouble, in this state of nervous tension which women call "nervousness." The ambra grisea patient is vivacious, excitable, hurried in her movements, lacking repose in the presence of company or friends; and so, after the ordeal has passed, she feels like a nervous wreck and suffers from any or all of these conditions. This is a very commonplace way of presenting the matter, but we think that this thread can be traced all through the ambra fabric.

SHOCK, PROPHYLAXIS AND TREATMENT.—Dr. Gilbert Fitz-Patrick recommends that oxygen be administered to the patient as soon as he or she leaves the operating table. If this be done, instead of a weak, imperceptible pulse, with shallow respiration and a state of exhaustion, the patient soon awakens with a good, free circulation, and the mind clear as though being aroused from a natural sleep. Oxygen relieved the hiccough of shock for the author. The anæsthetic odor of the exhaled breath, which is a constant *source of nausea*, is eliminated in a few minutes by the use of oxygen. Where nausea and vomiting are troublesome we may rely upon this agent, for a few inhalations will at once give relief. Next in value to the administration of this gas must be mentioned the external application of *dry heat* to the body and extremities, the use of copious *enemata of hot normal salt solution*, *alcoholic stimulants*, and the *inhalation of nitrite of amyl*.

(We feel like adding that veratrum album in the second or third decimal dilution, administered every few minutes, until reaction and comfort come, is one of the sure things which physicians and surgeons overlook.) The feeling at present seems to be against the use of strychnine, but it will take some

time yet before the ever ready "hypo. of strychn.—a sixtieth" ceases to resound through our hospitals. Dr. Fitz-Patrick has shown that there are better ways of treating shock, and his experiences should be listened to and confirmed.—*Hom. Jour. of Obstetrics.*

THE USES OF THE SALTS OF POTASH IN DISEASES OF THE EAR.—We wish that we had space enough at our disposal to give a *resume* of the entire paper by Dr. S. S. Kehr, but it may be found in our *Eye, Ear and Throat Journal* for November. When speaking of the Kali muriaticum, the author says that in this remedy the aurist has one of the most useful and positive of all remedies. In the treatment of chronic catarrhal conditions of the middle ear, it holds in check those cases which otherwise would go on from bad to worse, and result in permanent tissue changes. It suits the second or later stages of the catarrhal states of the naso-pharynx and Eustachian tube, which, by continuity of mucous membrane, extend to the cavity of the middle ear itself. The glands of the neck are swollen, and there is deafness and earache from swelling of the Eustachian tube. Granular condition of the external meatus and the membrana tympani. Moist exfoliation of the epithelial layer of tympanum, or a dry, scaly proliferation of the epidermis of the walls of the external meatus, with a tendency to atrophy of the parts. Crackling or snapping noises in the ears on blowing the nose or swallowing. Slowly progressive deafness with or without subjective noises in the ears; and, many times, without pain; consequent upon slow proliferation with interstitial thickening. The remedy is more frequently indicated in the non-suppurative than in the suppurative form. It is especially useful at the termination of an acute inflammation, to prevent its evil effects in inducing thickening of the mucous membrane of the tympanic cavity, and in modifying the tendency to adhesions, which constitutes one of the chief dangers.

The naso-pharynx presents the following conditions: Dry coryza; stuffiness of the nose; discharges are white and thick; epistaxis. Acute inflammation, with a decided burning dryness. Purulent form of acute nasal catarrh. Adherent crusts in the vault of the pharynx. Adenoid vegetations, when associated with follicular pharyngitis with the characteristic discharge. Throat covered with grayish patches or spots. Hawking of mucus from posterior nares. The base of the tongue is coated white or gray. And so Dr. Kehr takes up the different potash preparations, and talks about their uses, in this entertaining way.

ANOTHER CHAIR FOR THE MEDICAL COLLEGE.—Writers of medical editorials often shoot very keen arrows. This is no doubt necessary in order that their shafts may reach the mark aimed at. But they should never have used poisoned arrows. Dr. Kraft often shoots a very keen arrow, but the wounds it makes are healthy wounds. In *American Physician* for October he advocates the teaching of a little more "common sense" to medical students. He does not admire the professor who limits his services to the reading of his manuscript. He wants the professor to induct his students into the practical parts of medicine, as well. He wishes the medical colleges to teach more medicine, and more therapeutics. One of the most difficult problems that confronts the medical teacher is how to teach homœopathic therapeutics and materia medica in a way that will *attract* students to its study and practice, instead of repelling them and discouraging its further pursuit. This subject ought to make a good editorial theme.

THE PRACTICE OF MEDICINE AS A SCIENTIFIC PURSUIT.—It has been some time since we have read and re-read anything more charming than the address of Dr. F. Park Lewis, of Buffalo, upon the topic that heads this paragraph. The diction is so perfect, the arguments so persuasive, that it makes one wish that it were possible to believe this kindly spoken gentleman, when he says that *differences* of belief have been emphasized long enough; it is now time to emphasize *that which we hold in common*. He is speaking of and to the medical profession. Dr. Lewis thinks that the profession, as a whole, cannot be looked upon as a scientific body while it is divided by a question of belief. And this is true, because the primary characteristics of a truly scientific mind are openness, fairness, freedom from prejudice; without which how may any man find the truth? The truly scientific method is also characterized by the clearing away of the personal equation; and not all who would to-day be called scientists are great enough to pursue an end by this means. Dr. Lewis finds that the tendency of all modern thought is towards this direct, open, impersonal, systematic but mobile, in other words, scientific, attitude. And we are fairly amazed when he adds that the fair, unprejudiced, impersonal, exact, in other words scientific, attitude of mind, *has become characteristic of the medical profession*. And it humbles a man to the dust to have to admit to Dr. Lewis that he had not noticed this. And we have not noticed it. Dr. Lewis's words ring true, and the sentiments he expresses mark him as a true scientist and a gentleman. Yet he may be wrong. Not wrong in his sentiments and his own feelings, but wrong when he thinks that such are the sentiments and feelings of the whole profession. His noble thoughts have been born of the wish that is in his mind,—that such things *might be*. The whole homœopathic profession has been hoping and praying, for years, that the time *might* come when the mental attitude of the medical profession *would be* one, characterized by openness, fairness, absence of prejudice, and a desire to find the truth. We still say our prayers with regularity.

Dr. Lewis's address continues by stating that the spirit of the age is co-operative. The benefits of organization and co-operation are unquestionably great, and they are going to be tested as they never have been tested before; for the tide in that direction has just set in. It has become apparent to our author that medical co-operation is sure to come, in the near future. The mental attitude of the school makes this appear as a certainty,—to him. He believes that the whole question of school will ultimately be done away with, because it is unscientific. A method of medical practice is either capable of demonstration or of disproof, and for a profession to be divided on such a point is too absurd to much longer be permitted. Now, we think, comes the interesting part of the address. "But demonstration or disproof is not the work of an hour, and for many years to come the members of the profession *may* hold different views and use various methods in their work." We wonder whether Dr. Lewis looks forward to and longs for the demonstration of the truth of homœopathy, or its "disproof" and rejection. If he will accept the results of the labors of thousands of conscientious physicians, we may assure him that the *truth of homœopathy has been demonstrated*. Dr. Lewis admits that one *may* remain in ignorance because of unwillingness to put oneself in a position to gain the facts. "But," says he, "the possession of the facts will not always lead two men to the same conclusions."

In arranging this great co-operative medical trust, Dr. Lewis would have

but one question in the entrance examination. Has the candidate "a proper medical training, and has he the character of a gentleman?"

He ought to add another question: "Will you, sir, swear never to mention that dreadful word, homœopathy, again?" Don't organize the Trust, Dr. Lewis, until the time arrives when it will be perfectly safe for one to use the word homœopathy in the presence of a "regular" of apoplectic habit.

The address may be found in the *Medical Times* for last month. It is worth reading more than once.

CHIONANTHUS VIRGINICA.—If homœopaths would read some of the eclectic journals, and would catch that spirit of eagerness to establish the therapeutic utility of drugs by clinical experiment, and then report the results in journals, it would be a good thing. Many of our journals of last month did not contain a single article upon therapeutics. And yet that is what the majority of us like to read. Why do not some of our old practitioners write entertaining and useful papers upon homœopathic therapeutics? The average editor would welcome such papers with tears of joy, and his readers would also welcome the same—with renewed subscriptions. Dr. G. W. Boskowitz expresses himself as well pleased with the therapeutic effects of chionanthus, after an experience of more than fifteen years. He uses it for those non-inflammatory liver troubles for which calomel and podophyllum are usually prescribed,—perverted action of the liver, or, indeed, of the whole digestive tract, caused by over-indulgence or malaria. The liver is engorged and there is jaundice. The bile is discharged imperfectly, and there is catarrh of the common bile-duct. In such a condition there may be distress in the right hypochondrium, with cramp-like pains in the abdomen. This remedy, in very small doses of the tincture, seems to overcome the catarrh, liquefies the bile, prevents the formation of calculi, and promotes the discharge of those that have already formed. It will not cure the jaundice that has been produced by permanent occlusion of the duct, from impacted stones, or from malignant growths. It is particularly efficacious in the catarrhal jaundice of infants, children, and of pregnant women. Now, we think these observations are very useful.—*Eclectic Review. Medical Gleaner.*

TUBERCULINUM,—AN EXPOSITION.—Almost invariably, when we are treated to an article on tuberculinum, it appears in one of the German homœopathic medical journals. The greatest champion of this nosode was, however, not a German, but an Englishman—Burnett. It is difficult to find worse nonsense than the writings of this distinguished Englishman, especially his writings on the cure of consumption. Not in a single case was a physical examination or a bacteriological investigation of the sputum made,—the data nowadays required by every intelligent physician before he can accept the diagnosis of phthisis pulmonalis,—and still the writer presents an array of cases in which he claims to have cured the disease, the only proof being his say so.

We are pleased to find Dr. von Baurittel protest against this sort of practice. He strongly opposes the view that isopathy has anything in common with homœopathy, and urges that we expunge the nosodes from our *Materia Medica*. Bibring's antitoxin of diphtheria, on the other hand, is a true prophylactic, as is also Pasteur's hydrophobin, and they have nothing to do with isopathy.

He points out that while Dr. Burnett claims to have cured his patients with

baeillinum (potentized sputum from a tuberculous patient), still, in every instance were other remedies prescribed at the same time, notably hydrastis in tincture. The inconsistency of this mode of practice must appeal to all ; but it fits in very nicely with the unscientific clinical methods of said Burnett.

Dr. Baurittel labels his article "Zur Aufklärung homöopathischer Verirrungen," which is synonymous with "an exposition of some of the fallacies that have crept into homœopathy."—*Zeitschrift des Berliner Vereins Homöopathischer Aertze*, October, 1902.

HAY FEVER NOTE.—Dr. A. G. Downer, of Princeton, Ill., again calls the attention of physicians to *corn pollen* as a remedy for hay fever and fall colds. He makes his tincture of husks, silks, leaves and tops of corn, and has it potentized to the 50x. He claims wonderful results, and is willing to send grafts to those who are willing to report its effects to him.—*Hahnemannian Advocate*.

AN ECLECTIC IDEA OF THE LAW OF CURE. —Dr. Triplett, in *Eclectic Gleaner*, says: "A large dose of a drug will make a well man sick. A relatively small dose will cure a similar sickness of the same organ or part. Why? Because a drug can only cure by the same action as that by which it can cause disease. It can only cure disease of the same organ or part in which it can cause disease. It only cures where it acts. Large doses force physiology to abnormal action. Small doses lead abnormal physiology back to normal action. To get the action *contraria*, the remedy must be selected by *similia*." Modern investigators who are seeking to discover the Law of Cure will find a short cut to their destination in a book called *The Organon*, written by an ancient investigator, signing himself S. Hahnemann. If they should meet, from time to time, with a certain offensive word—homeopathy—it will be easy to skip that. There is nothing unpleasant about the book.

THE ACQUIREMENT OF THE DRUG HABIT.—Every physician should read the report of the committee appointed by the American Pharmaceutical Association to inquire into the matter of drug habits, and how they are acquired. This report has been published in *American Journal of Pharmacy* for November. The responsibilities of the pharmacist are very plainly shown. A careful investigation among physicians assures us that the legitimate use of cocaine has not increased, since its greater use in general surgery is offset by a more careful use in nose and throat work and in general practice. Because of its known dangerous character, it is, of late, seldom ordered in a prescription to be handled by the patient. In the face of such facts, the increase of over 400 per cent. in the imports of cocaine since 1898 is very significant, while the increase of nearly 500 per cent. in the quantities of opium and morphine is simply startling. As the report was being prepared, a despatch came from San Francisco announcing that over \$1,000,000 worth of opium had just reached that port of entry in one cargo. The police of certain questionable localities informed the committee that the use of cocaine by women and negroes is simply appalling. These habits have no difficulty at all in buying the drug ; sometimes it is even peddled around to them from door to door. It is generally adulterated with acetanilid. Much of the insanity and nervous derangement prevalent is thought to be due to drug habits, and crime is very often directly traceable to its impulses. Preparations containing caffeine and acetanilid, in combination, come in for their full share of blame in this report ; so do chloroform, ether and catarrh snuffs, besides other drugs.

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CONTRIBUTORS TO VOLUME XXXVII.

- Adams, T. Louis, M.D., Philadelphia.
 Ashcraft, Leon T., A.M., M.D., Philadelphia.
 Askenstedt, Fritz C., M.D., Louisville, Ky.
 Baker, Wm. F., A.M., M.D., Philadelphia.
 Bartlett, Clarence, M.D., Philadelphia.
 Bayley, Weston D., M.D., Philadelphia.
 Belville, J. E., A.M., M.D., Philadelphia.
 Bender, Edw. A., Ph. G., Philadelphia.
 Bigler, Wm. H., A.M., M.D., Philadelphia.
 Bissell, Elmer Jefferson, M.D., Rochester, N. Y.
 Boericke, F. A., M.D., Philadelphia.
 Brown, S. G. A., M.D., Mechanicsburg, Pa.
 Carmichael, T. H., M.D., Philadelphia.
 Chase, Theo. L., M.D., Philadelphia.
 Christine, G. M., M.D., Philadelphia.
 Copeland, Royal S., M.D., Ann Arbor, Mich.
 Critchlow, Geo. R., M.D., Buffalo, N. Y.
 Crichton, Macpherson, M.D., Washington, D. C.
 Day, J. Roberson, M.D., London, England.
 Dobson, C. H., M.D., Ardmore, Pa.
 Duncan, T. C., M.D., Chicago, Ill.
 Gifford, Willis B., M.D., Attica, N. Y.
 Golden, G. Morris, M.D., Philadelphia.
 Goodno, Wm. C., M.D., Philadelphia.
 Gramm, Theo. J., M.D., Philadelphia.
 Haines, O. S., M.D., Philadelphia.
 Helfrich, Chas. H., M.D., New York City.
 Howard, E. M., M.D., Camden, N. J.
 Hutchinson, John, M.D., New York.
 Ingersoll, W. K., M.D., Philadelphia.
 Izzard, Ralph I., M.D., Haddonfield, N. J.
 King, Wm. Harvey, M.D., New York City.
 Korndorfer, Aug., M.D., Philadelphia.
 Laidlaw, Geo. F., M.D., New York City.
 Laird, F. F., M.D., Los Angeles, Cal.
 Lawrence, F. Mortimer, M.D., Philadelphia.
 Leopold, Herbert P., M.D., Philadelphia.
 Luton, L. S., M.D., Grand Rapids, Mich.
 Lyle, Wm. H., M.D., Philadelphia.
 Macdonald, T. L., M.D., Washington, D. C.
 Mack, Chas. S., M.D., La Porte, Ind.
 Middleton, C. S., M.D., Philadelphia.
 Mills, Walter Sands, M.D., New York.
 Mitchell, Clifford, M.D., Chicago, Ill.
 Mohr, Chas., M.D., Philadelphia.
 Northrop, Herbert L., M.D., Philadelphia.
 Paxson, O. H., M.D., Philadelphia.
 Platt, Chas., M.D., Ph.D., Philadelphia.
 Pritchard, Frank H., M.D., Monroeville, Ohio.
 Raue, C. Sigmund, M.D., Philadelphia.
 Rice, A. B., M.D., Jamestown, N. Y.
 Runnels, O. S., M.D., Indianapolis, Ind.
 Searle, W. S., M.D., Brooklyn, N. Y.
 Snader, E. R., M.D., Philadelphia.
 Southwick, Geo. R., M.D., Boston, Mass.
 Speakman, Wm. W., M.D., Philadelphia.
 Spencer, Wm., M.D., Philadelphia.
 Stirk, J. C., M.D., Philadelphia.
 Swift, E. P., M.D., New York City.
 Trew, Bartus, M.D., Baltimore, Md.
 Tuller, Jno. J., M.D., Philadelphia.
 Usilton, M. E., M.D., Philadelphia.
 Vandenburg, M.W., M.D., Mt. Vernon, N.Y.
 Van Den Burg, Wm. H., M.D., New York City.
 Van Lennep, Gustav, M.D., Philadelphia.
 Van Lennep, Wm. B., A.M., M.D., Philadelphia.
 Wanstall, Alfred, M.D., Baltimore, Md.
 Weaver, H. S., M.D., Philadelphia.
 Wilbur, Bertrand K., M.D., Ardmore, Pa.
 Wilcox, Sidney F., M.D., New York City.
 Winans, Wm. W., M.D., Rochester, N. Y.
 Wyborn, Jno. M., M.D., F.C.S., London, England.
 Yale, Arthur W., M.D., Philadelphia.

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EDITED BY

HERBERT P. LEOPOLD, M.D.

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American Edition of Nothnagel's Practice. Diseases of the Bronchi and Pleura; Pneumonia. Diseases of the Bronchi, by Dr. F. A. Hoffmann, of Leipsic. Diseases of the Pleura, by Dr. O. Rosenbach, of Berlin. Pneumonia, by Dr. F. Aufrecht, of Magdeburg. Edited, with additions, by John H. Musser, M.D., Professor of Clinical Medicine, University of Pennsylvania. Handsome octavo volume of 1030 pages, illustrated, including 7 full-page colored lithographic plates. Philadelphia and London : W. B. Saunders & Co., 1902. Cloth, \$5.00 net ; half morocco, \$6.00 net.

Nothnagel's Practice belongs to the class of encyclopædic works which, by intrinsic merit, force themselves into the libraries of all progressive clinicians. The present volume, under the editorship of Musser, fulfills the expectations awakened by its predecessors. The editor, however, very modestly remarks that the eminent authors of the several monographs which make up the volume have, by their breadth of learning, their exhaustive research, and, above all, by their extensive practical experience, made their essays so complete that he has found very little to add. Among other things, these additions include new matter on the anatomy and physiology of the bronchi; on foreign bodies in the tubes; on the pathology, bacteriology, and treatment of bronchitis, and the recent researches on bronchiectasis and on eosinophilia in asthma.

Much new matter has been incorporated into the section on Pneumonia, including the recent work of Hutchinson and others on the blood and urine in that disease. In the Pleurisy section will be found an account of the latest bacteriologic studies, and references to the work of Morse on the leucocytes in pleurisy, to that of Williams and others on X-ray diagnosis, and to the Litten phenomenon. The work in every particular is thoroughly up-to-date, and no criticism is possible but praise.

A Text-Book of Anatomy.—By American authors. Edited by Frederic Henry Gerrish, M.D., Professor of Anatomy in the Medical School of Maine, Bowdoin College. Second edition, thoroughly revised and enlarged. In one imperial octavo volume of 943 pages, with 1003 engravings in black and colors. Cloth, \$6.50 net. Leather, \$7.50 net. Flexible water-proof binding, for use on the dissecting-table, \$7.00 net. Lea Brothers & Co., Publishers, Philadelphia and New York.

An anatomy as profusely illustrated as is Gerrish's requires an unusually large sale to make it successful to the publishers. This evidently has been the case, for now we are confronted with a second edition two years after the appearance of the first. The arrangement of the work is along familiar lines, the ordinary divisions of systematic anatomy having been followed in the main. Each author has set forth his subject in such manner as experience has shown him to be profitable. Great stress has been laid upon visceral structure without neglect of other branches. Surface anatomy, a subject much neglected, has received the attention required by its importance. As to illustrations, the publishers make the claim, which we believe to be well-founded, that it is the most profusely illustrated one-volume work on any medical subject, for it contains over 1000 illustrations, many of them in colors. In the preparation of the second edition every section has been critically examined for possible improvement. Such changes have been made as were rendered necessary by the progress of anatomical science, and new matter has been added wherever desirable and consonant with the general scope of the book. Particular attention has been paid to relational anatomy. Instead of the schematic device previously employed for showing the relations of the principal arteries, a series of horizontal sections at different levels has been prepared, the various parts being labelled directly with their names wherever feasible. Gerrish's "Anatomy," to our mind, is the only work that can be considered a competitor of Gray.

Reynolds & Newell's Practical Midwifery. A Manual of Obstetrics for Students and Physicians. By Edward Reynolds, M.D., Assistant in Obstetrics, etc., and Franklin S. Newell, M.D., Assistant in Obstetrics and Gynecology in Harvard University Medical School, Boston. In one octavo volume of 531 pages, with 253 engravings, and 3 full-page colored plates. Cloth, \$3.75, net. Lea Brothers & Co., Publishers, Philadelphia and New York. 1902.

This book coming to us to-day, when obstetric text-books are so numerous, is very acceptable, in the first place because it comes from the pens of two men in whom we all place confidence, and, further, because it carries out fully what is claimed for it, in that it states concisely a method of obstetrics. It teaches a school of obstetrics, a system which, if learned and practiced, undoubtedly will make a successful accoucheur.

The chapters on normal and delayed labor present the subject in such a manner that only modern methods are discussed. Many suggestions are made, many small points to be remembered are stated; points which the practiced man involuntarily performs, but which the student must learn before he can hope to become a thoroughly competent bedside obstetrician.

Pathologic midwifery is treated in a manner that definitely and accurately sets forth the diagnosis, indications and contra-indications, and treatment for the various abnormal conditions that may exist or arise calling for the immediate interference on the part of the obstetric surgeon.

The sections on the new-born and the premature child are indeed invaluable, and outline the matter in a form thoroughly purged of all the obsolete teachings of the past, and at the same time avoid the confusing theory which does so much to confound the student. Artificial feeding and kindred subjects relating to the infant are carefully considered.

On the whole the book can be recommended as a modern treatise which lays out a definite line of teaching, such as has been attended with success in the hands of the authors, and which undoubtedly will bring no failure to the man acquiring a good working knowledge of the subject as taught in this manual.

A Manual of Gynæcology. By Henry T. Byford, M.D., Professor of Gynæcology and Clinical Gynæcology in the College of Physicians and Surgeons of Chicago; Professor of Gynæcology in the Post-Graduate Medical School of Chicago, and in the Chicago Clinical School. Third revised edition. Containing 360 illustrations, many of which are original. Philadelphia: P. Blakiston's Son & Co. 1902. Price, \$3.00 net.

In preparing the third edition, the author has recast the contents of the book and has added much new matter. He has endeavored to render the book not only as concise, but at the same time as complete as possible. To the busy practitioner who does but a small amount of gynæcological surgery, it will be found as complete for his purpose as is desirable, without being rendered cumbersome by extended descriptions and copious illustrations of major operations. To avoid delay in looking up the numerous references contained in the text, there have been placed at the top of every second page the part and chapter to which the page belongs.

The marginal notes have been somewhat amplified, with the intention of enabling the student, by looking at the first line of a paragraph and glancing down the marginal notes, to recall the contents of the paragraph with which he is familiar and determine quickly whether he must read them over again, or may pass to the next.

The parts have been rearranged. Anatomy, physiology and gynæcological diagnosis have been put into the introduction, since they would be of more use to the student for reference or in a preliminary or special course, rather than as a part of the regular course.

Practical Diagnosis: The Use of Symptoms and Physical Signs in the Diagnosis of Disease. Fifth edition, revised and enlarged. By Hobart Amory Hare, M.D., B.Sc., Professor of Therapeutics in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; one time Clinical Professor of Diseases of Children in the University of Penn-

sylvania: Laureate of the Medical Society of London, etc., etc. Illustrated with 236 engravings and 25 plates. Lea Brothers & Co., Philadelphia and New York. 1902. Price, \$5.00.

A new edition of a practical work on diagnosis, owing to the rapid advances made in clinical and laboratory methods and examination technique, must necessarily show marked changes as compared with its predecessors; and this we find is the case with Hare's *Diagnosis*. Nominally, it is a work by itself. Practically, it is a treatise on diagnosis, with a companion work on therapeutics,—each volume having been prepared by reason of suggestions offered by the other. The primary object of the work is to present the symptoms of disease as they appear, and from this group of symptoms to arrive at a diagnosis, following the methods which are ordinarily employed at the bedside. The present edition differs materially from its predecessors in the fact that its scope has been broadened to include not only the symptoms discussed in the manner just described, but also the physical signs and clinical tests which experience has proved to be reliable. These have been considered much more fully than before with the object of making the book as complete as possible. A large number of illustrations, most of them dealing with actual cases, have been introduced.

The author's style is conversational. This, while open to the objection of lacking condensation, offers, as a compensating advantage, ease of perusal, which is a comfort when reading after a day's hard work.

A Text-Book of Pathology and Pathological Anatomy. By Dr. Hans Schmaus, Professor in the Pathological Institute at Munich. Translated from the sixth German edition by A. E. Thayer, M.D., Instructor in Pathology, and edited, with additions, by James Ewing, M.D., Professor of Pathology in Cornell University Medical College, New York. In one octavo volume of 597 pages, with 351 illustrations, including 35 colored inset plates. Cloth, \$4.00 net. Lea Brothers & Co., Publishers. Philadelphia and New York.

This work has won the foremost place in Germany, where pathology is valued as of paramount importance, and is studied with corresponding results. The reason for its great popularity—six editions in the original having already been demanded—is easily discernible upon examination of the volume now for the first time presented in English. It is conspicuous for its close adaptation to the needs of students and practitioners alike. The author has written a compact, comprehensive book, embodying every important principle and fact, clearly stated, and illustrated with an exceedingly rich series of engravings and colored plates. Instead of a mass of discursive or argumentative matter and of the pursuit of personal opinions, Dr. Schmaus has given a clear, concise statement of present knowledge, amplified with a rich array of aptly-chosen instances and references, never before equaled in a text-book on this subject.

The work of the American editor deserves unstinted praise, as one would expect from one occupying his high official connection with one of the great medical schools. The mechanical execution of the book is likewise praiseworthy, especially in the matter of illustrations, which are all designed to instruct, and, what is more important, succeed in doing what they are intended to do.

Bacteriological Technique. A Laboratory Guide for the Medical, Dental, and Technical Student. By J. W. H. Eyre, M.D., F.R.S., Edin., Bacteriologist to Guy's Hospital, and Lecturer on Bacteriology at the Medical and Dental Schools, etc. Octavo of 375 pages, with 170 illustrations. Philadelphia and London: W. B. Saunders & Co., 1902. Cloth, \$2.50 net. This book is an excellent one. It presents, concisely yet clearly, the various

methods at present in use for the study of bacteria, and elucidates such points in their life-histories as are debatable or still undetermined. Moreover, it does not encumber the student with the many uncertain methods usually crowded into books of this kind, only those being included that are capable of giving satisfactory results even in the hands of beginners.

The excellent and appropriate terminology of Chester has been adopted throughout. This is a very commendable feature, as Chester's terminology needs but a trial to convince one of its extreme utility; and its inclusion in an elementary manual is calculated to induce in the student habits of accurate observation and concise description.

The illustrations are numerous and practical, the author considering, and rightly so, that a picture, if good, possesses a higher educational value and conveys a more accurate impression than a page of print.

The work is not intended for the medical and dental student alone, having been designed with the needs of the technical student generally constantly in view, whether he be of brewing, dairying, or agriculture.

Of the many laboratory guides and technical manuals constantly being issued, this is, without question, for a book of its pretensions, the best that has reached us.

Diseases of the Pancreas and their Surgical Treatment. By A. W. Mayo Robson, F.R.C.S., Senior Surgeon, Leeds General Infirmary; Emeritus Professor of Surgery, Yorkshire College, Victoria University, England; and B. G. A. Moynihan, M. S. (Lond.), F.R.C.S., Assistant Surgeon, Leeds General Infirmary; Consulting Surgeon to the Skipton and to the Mirfield Memorial Hospitals, England. Handsome octavo volume of 293 pages, illustrated. Philadelphia and London: W. B. Saunders & Co. 1902. Cloth, \$3.00 net.

This work, dealing with the surgical aspect of pancreatic disease, has been written with a twofold object: to record and to review the work done in the past, and to indicate, so far as possible, the scope and trend of future research. We can state freely and unreservedly that the objects aimed for could not have been better accomplished. It is only within recent years that any material progress in regard to our knowledge of the functions and diseases of the pancreas has been made, and a work like the present volume, the combined efforts of two such distinguished surgeons, will most certainly be welcomed by the profession.

The work is an excellent one, and, besides containing a very commendable exposition of the various diseases and injuries of the pancreas, it includes an accurate account of the anatomy, abnormalities, development and structure of the gland. We endorse the work most heartily, and believe every physician and surgeon will find its perusal of unusual advantage.

The Development of the Human Body. A Manual of Embryology.

By J. Playfair McMurrich, A.M., Ph.D., Professor of Anatomy in the University of Michigan. With 270 illustrations. Philadelphia: P. Blakiston's Son & Co. 1902. Price, \$3.00 net.

The assimilation of the enormous mass of facts which constitute what is usually known as descriptive anatomy has always been a difficult task for the student. Part of the difficulty has been due to a lack of information regarding the causes which have determined structure and relations of the parts of the body, for, without some knowledge of why things are so, the facts of anatomy stand as so many isolated items, while with such knowledge, they become bound together in a continuous whole, and their study assumes the dignity of a science.

The great key to the significance of the structure and relations of organs is their development, recognizing by that term the historical as well as the individual development; and the work before us constitutes an attempt to present a concise statement of the development of the human body, and a foundation for the proper understanding of the facts of anatomy. Naturally, the individual development claims the major share of attention, since its processes are the more immediate forces at work in determining the conditions in the adult; but where the embryological record fails to afford the required data, whether from actual imperfection or from the incompleteness of our knowledge concerning it, recourse has been had to the facts of comparative anatomy, as affording indications of the historical development or evolution of the part under consideration.

Text-Book of Medical Jurisprudence and Toxicology. By John J. Reese, M.D., late Professor of Medical Jurisprudence and Toxicology in the University of Pennsylvania; late President of the Medical Jurisprudence Society of Philadelphia. Sixth edition. Revised by Henry Leffman, A.M., M.D., Professor of Chemistry and Toxicology in the Woman's Medical College of Pennsylvania; Pathological Chemist to the Jefferson Medical College Hospital; Vice-President (British) Society of Public Analysts. Philadelphia: P. Blakiston's Son & Co. 1902. Price, \$3.00 net.

The standing and authority of Reese's Medical Jurisprudence requires no praise from us at this late day, for the work has been a standard one in the English language for many years. Concerning the sixth edition, as edited by Professor Leffman, some few words are in order. Since the publication of the last edition of this work, the subject of toxicology has been much developed. The introduction of numerous synthetic organic bodies, and the extensive use of some of them as household remedies, have given rise to many instances of accidental and suicidal poisoning. Current medical literature shows that phenol is becoming one of the most common agents for self-destruction, while the extensive use of water-gas greatly increases the list of accidental poisonings.

Several new phases of treatment may be noted. Free washing out of the stomach is evidently, whenever possible, a highly beneficial procedure. The employment of alcohol in phenol poisoning is an important advance. Potassium permanganate has also found valuable applications. It is also to be noted that the long-current belief in the antidotal value of atropine in morphia poisoning has been abandoned.

The editor has sought to include the recent data of trustworthy character, and has inserted brief descriptions of many cases recently reported. The general character of the book as it left the hand of its distinguished author has been retained.

The Treatment of Tabetic Ataxia by Means of Systematic Exercise. An Exposition of its Principles and Practice of Compensatory Movement Treatment. By H. S. Frenkel, Medical Superintendent of the Sanatorium "Freihof" in Heiden (Switzerland). Only authorized English edition. Translated and edited by L. Freyberger, M.D. (Vienna), M.R.C.P., Lond., M.R.C.S., Eng. Hon. Physician to the St. Pancras and Northern Dispensary; Pathologist to the Great Northern Central Hospital; Late Clinical Assistant to the Hospital for Sick Children, Great Ormond St., etc., etc. With 132 illustrations. Philadelphia: P. Blakiston's Son & Co. 1902. Price, \$3.00.

This work belongs to a class of which we truly wish there were many more published. It is a monograph devoted entirely to the treatment of locomotor

ataxia by systematic exercise. We have long been acquainted with the principles underlying the Frenkel treatment, and have made use of the same in the management of our patients. The treatment is a most simple one. The physician can readily devise numerous movements for his patients without forcing them to go to a sanitarium. As to apparatus, most of that required can be constructed at home; even the most complicated can be built by a carpenter at a nominal cost. We commend the work to every physician who, having a case of locomotor ataxia to treat, wishes to do the best possible for his client.

International Clinics. A Quarterly of Illustrated Clinical Lectures and especially prepared Articles on Medicine, Neurology, Surgery, Therapeutics, Obstetrics, Pædiatrics, Pathology, Dermatology, Diseases of the Eye, Ear, Nose, and Throat, and other Topics of Interest to Students and Practitioners by leading Members of the Medical Profession throughout the World. Edited by Henry W. Cattell, A.M., M.D., Philadelphia, U. S. A., with the Collaboration of John B. Murphy, M.D., Chicago; Alexander D. Blackader, M.D., Montreal; H. C. Wood, M.D., Philadelphia; T. M. Rotch, M.D., Boston; E. Landolt, M.D., Paris; Thomas G. Morton, M.D., Philadelphia; James J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh, and John Harold, M.D., London, with Regular Correspondents in Montreal, London, Paris, Leipsic, and Vienna. J. B. Lippincott Company. Philadelphia and London. Cloth, \$2.00. Volume 3, Series 12th.

We are pleased to note that the alleged biographical sketches of prominent physicians which graced the previous numbers of this invaluable serial publication have been omitted. We are now treated to solid scientific knowledge of clinical value; this and this only; and it is just what we want. That clinical lectures when properly digested are popular is attested by the twelve years of prosperity of the Clinics.

The present number has important therapeutic articles on typhoid fever—a subject presenting never ending phases,—urticaria, and the treatment of deafness by direct massage of the ossicle of the ear. An innovation which is to be praised is the publication of a number of practical hints, occupying each about half of a printed page.

The special articles of the volume include "The Function of the Digestive Glands," based upon the researches of Pavlov and his pupils, by Borissof, and a "Critical Study of the Theory of Inflammation," by Schmaus, whose invaluable work on Pathology is noticed on another page of this number of the *HAHNEMANNIAN*.

A Pocket Text-Book of Dermatology. By Joseph Grindon, M.D., Professor of Clinical Dermatology and Syphilis in the Medical Department of Washington University, St. Louis. In one 12mo. volume of 367 pages, with 39 illustrations, in black and colors. Lea's Series of Pocket Text-Books. Edited by Bern B. Gallaudet, M.D. Cloth, \$2.00 net; Limp Leather, \$2.50 net. Lea Brothers & Co., Publishers. Philadelphia and New York.

Like its companion volumes of Lea's Series of Pocket Text-Books, this work gives a compact compendious and trustworthy account of its subject, embodying the most recent developments. It is not only sufficiently complete in essentials for the use of students, but also comprehensive enough, especially in pathology and treatment, to be of value to the physician as a means of both refreshing his recollection and of posting himself to date. In the preparation of the work, the author has drawn freely from modern sources.

Dr. Grindon's eminent fitness for the production of a work of great practical value will not be questioned; he has given freely from his clinical experi-

ence, and his many years of teaching have enabled him to furnish a help to both teacher and student which tends directly to minimum time and toil with maximum results.

Lea's Series of Medical Epitomes. A Manual of Genito-Urinary and Venereal Diseases for the use of Students and Practitioners. By Louis E. Schmidt, M.D., of the Chicago Polyclinic. In one handy 12mo. volume of 250 pages, with 21 illustrations. Cloth, \$1.00 net. Lea Brothers & Co., Publishers. Philadelphia and New York. 1902.

The present volume endeavors to cover the subject of genito-urinary and venereal diseases briefly and clearly, to afford a comprehensive survey within a compact space, as a camera condenses a landscape, preserving all essentials in their proper place and proportion. In this way it has been possible to devote special attention to the more important diseases, their diagnosis and treatment, and to present the most trustworthy and practical, medical and surgical therapeutics.

Though this work represents in a large measure the results of personal experience, reference has been freely made to the standard works of Keyes and Chetwood, Hyde and Montgomery, Neisser, Finger, Joseph, and many others.

A Compend of Human Physiology, Especially Adapted for the Use of Medical Students. By Albert P. Brubaker, A.M., M.D., Adjunct Professor of Physiology in the Jefferson Medical College; Professor of Physiology in the Pennsylvania College of Dental Surgery; Lecturer on Anatomy and Physiology in the Drexel Institute of Art, Science and Industry, etc. Eleventh edition, revised and enlarged. With illustrations and a table of physiologic constants. Philadelphia: P. Blakiston's Son & Co. 1902. Price, 80 cents.

The opportunity for a new edition has enabled the author to revise the old and to insert some new matter,—changes which will undoubtedly be to the advantage of the medical student during his attendance on lectures. This compend will continue, as before, to meet the demands of the student of medicine.

The Medical News Visiting List for 1903. Weekly (dated, for 30 patients); Monthly (undated, for 120 patients per month); Perpetual (undated, for 30 patients weekly per year); and Perpetual (undated, for 60 patients weekly per year). The first three styles contain 32 pages of data and 160 pages of blanks. The 60-patient Perpetual consists of 256 pages of blanks. Each style in one wallet-shaped book, with pocket, pencil and rubber. Seal Grain Leather, \$1.25. Thumb-letter Index, 25 cents extra. Lea Brothers & Co., Publishers. Philadelphia and New York.

Publishers' Notices.—The work on "Diagnosis," by Dr. Clarence Bartlett, has been delayed by the time required in the preparation of certain plates in color; but the publishers, Messrs. Boericke & Tafel, promise it to the profession on or before December 1st.

The unexpected demand for another edition of Dr. Bukk G. Carleton's "Uropoietic Diseases" is only another evidence of the popularity of that work. The author's more recent experience, together with the more lately published opinions of others, are embodied in the new (3d) edition, making it a thoroughly up-to-date reference-book on diseases of the bladder and kidneys for the busy physician. The book consists of 422 pages, and sells for \$3.50. Boericke & Runyon, of New York, are the publishers.

New York State Homœopathic Medical Society.—The Homœopathic Medical Society of the State of New York held its Thirty-sixth semi-

annual meetings in Utica, September 16th and 17th. It was one of the most delightful and successful meetings in the history of the Society. The Local Committee, with Dr. Haines as Chairman, were such hospitable hosts that every attendant felt he was personally welcome and well cared for.

The programme was as follows:

Tuesday Morning.

10 A.M. Prayer, Rev. Henry H. Tweedy. Address of Welcome, By the Mayor, Hon. Charles A. Talcott. Communications from the President. Appointment of Committees: On Attendance, On Auditing. Minutes of last meeting. Reports: Treasurer, Frederick J. Cox; Necrologist, W. S. Garnsey; Board of Censors; Committee on Increasing Membership, H. D. Schenck; On Medical Legislation, E. H. Porter; On Life Insurance Companies, J. D. Zwetsch; On Local Arrangements, C. T. Haines; Press Committee, A. Drury; Delegates to the American Institute of Homœopathy. Miscellaneous Business. 11 A.M. Bureau of Gynæcology, S. R. Snow, Chairman; "The Advantages of Homœopathy in Gynæcology," Emily F. Swett; Discussion opened by C. E. Chase. "Appendicitis Occurring During Pregnancy," J. H. Schall; Discussion opened by F. E. Caldwell, "Experiences Derived from a Series of Peritoneal Operations," J. M. Lee; "One of Those Peculiar Cases," DeWitt G. Wilcox. 12 M. Bureau of Neurology, P. W. Neefus, Chairman; "An Anatomical Factor in Mental and Nervous Diseases," Arthur Palen Powelson; Discussion opened by Daniel H. Arthur; "According to Hudson," John T. Greenleaf; Discussion opened by John W. LeSeur. 12.20 P.M. Bureau of Obstetrics, C. G. Capron, Chairman; "An Old Story Retold," J. Willis Candee; "Let Nature Take Its Course," L. A. Martin; "The Routine Course of Chloroform Anæsthesia," A. R. Grant.

Tuesday Afternoon.

2.30 P.M. Bureau of Ophthalmology and Otology, J. Ivimey Dowling, Chairman; "Conjunctivitis," L. W. Dean. 2.45 P.M. Bureau of Pædiatrics, E. H. Noble, Chairman; "Infant Feeding," W. C. Daley; "A Consideration of Some Pathological Conditions of the Blood in Early Life," John G. Chadwick; "Meningitis," W. S. Rambo; "A Case," Julia F. Haywood; "The Influence of Preputial Adhesions upon the Nervous System," Mark S. Purdy. 3.15 P.M. Bureau of Surgery, Orlando S. Ritch, Chairman; "The Dangers of Modern Surgery," S. R. Snow; "The Mystery of Infection," George Clinton Jeffrey; "Ligation of Arteries Preliminary to the Removal of Malignant Growths, with Report of Cases," William Francis Honan; "The Treatment of Post-operative Complications," George T. Moseley. 4.15 P.M. Bureau of Public Health (Speechless), D. G. Van Ostrand, Chairman. 4.30 P.M. Bureau of Laryngology and Rhinology, A. Worrall Palmer, Chairman; "Tonsils," Fred. D. Lewis. 4.45 P.M. Miscellaneous Business.

Tuesday Evening.

8 P.M. Banquet at Masonic Hall. Every body and his wife was there.

Wednesday Morning.

10 A.M. Bureau of Materia Medica, Walter Sands Mills, Chairman; "Application of Hahnemann's Principles in the Treatment of Acute Diseases," H. C. Allen; "What We Need in Materia Medica To-Day," M. W. Vandenburg; "Fragmentary Notes on Ichthyol," S. A. Jones. 11 A.M. Bureau of Clinical Medicine and Pathology, George R. Critchlow, Chairman; "Primary Colloid Cancer of the Omentum, with the Report of a Case Complicated with Pulmonary

Tuberculosis, Cirrhosis of the Liver and Nephritis." Egbert Guernsey Rankin; Discussion opened by D. G. Wilcox; "A New Method for Outlining the Separate Cavities of the Heart," George Frederick Laidlaw; Discussion opened by Burt J. Maycock; "X-ray Treatment of Tuberculosis of the Bones, Joints and Skin," W. Harvey King; "The Practice of Medicine as a Scientific Pursuit," F. Park Lewis; Discussion opened by George E. Gorham. 12 M. Miscellaneous Business. Report of Committee on Attendance. Unfinished Business. Adjournment.

Very little general business came in for attention, and hence the full time was given up to scientific work.

Officers 1902-1903.—*President*, John L. Moffat, 1136 Dean Street, New York, Brooklyn; *Vice-Presidents*, Maurice C. Ashley, Middletown; Bukk G. Carleton, 75 West 50th Street, New York, Manhattan; Charles A. Gwynn, 13 Grover Street, Auburn; *Secretary*, DeWitt G. Wilcox, 597 Elmwood Ave., Buffalo; *Treasurer*, Frederick J. Cox, 109 State Street, Albany; *Neurologist*, W. S. Garnsey, 93 N. Main Street, Gloversville; *Counsel*, Frederick E. Wadhams, Esq., 33 Tweddle Building, Albany.

Those in attendance were M. C. Ashley, Middletown; T. D. Buchanan, New York; Wm. M. Butler, Brooklyn; J. W. Candee, Syracuse; C. G. Capron, Utica; B. G. Carleton, New York; John G. Chadwick, Buffalo; C. E. Chase, Utica; F. J. Cox, Albany; George R. Critchlow, Buffalo; W. C. Daley, Rochester; L. L. Danforth, New York; L. W. Dean, Utica; Walter G. Crump, New York; W. A. Dewey, Ann Arbor, Mich.; J. I. Dowling, Albany; F. LeC. Dowe, New York; J. W. Dowling, New York; Wm. P. Faust, Schenectady; W. S. Garnsey, Gloversville; C. Gennerich, New York; A. D. Getman, Oneonta; G. L. Gifford, Hamilton; W. B. Gifford, Attica; G. E. Gorham, Albany; A. R. Grant, Utica; C. A. Gwynn, Auburn; J. T. Greenleaf, Owego; C. T. Haines, Utica; J. H. Hallock, Saranac Lake; F. W. Hamlin, New York; E. L. Hill, Gloversville; W. F. Honan, New York; R. B. Howland, Elmira; S. W. Hurd, Lockport; G. C. Jeffery, Brooklyn; J. M. Jeese, Syracuse; Wm. Harvey King, New York; George F. Laidlaw, New York; Charles E. Lane, Poughkeepsie; J. M. Lee, Rochester; John W. LeSeur, Batavia; F. D. Lewis, Batavia; F. Park Lewis, Buffalo; L. A. Martin, Binghamton; J. A. MacKenzie, Lima; George W. McDowell, New York; Walter S. Mills, New York; C. J. Miller, Mt. Kisco; J. L. Moffat, Brooklyn; George T. Moseley, Buffalo; E. B. Nash, Cortland; P. W. Neefus, Rochester; W. H. Nickelson, Adams; E. H. Noble, Elmira; C. F. Otis, Honeoye Falls; A. P. Powelson, New York; E. G. Rankin, New York; W. S. Rambo, Rochester; E. S. Randall, Waterville; Jos. Rieger, Dunkirk; D. J. Roberts, New Rochelle; G. W. Roberts, New York; F. E. Roper, Norwich; J. H. Schall, Brooklyn; N. C. Scudder, Rome; F. W. Seward, Jr., Goshen; J. W. Sheldon, Syracuse; B. F. Sherwood, Syracuse; J. T. Simonson, New York; E. A. Simonds, Carthage; S. R. Snow, Rochester; E. E. Snyder, Binghamton; A. B. Southwick, Rome; T. D. Spencer, Rochester; M. O. Terry, Utica; A. B. Van Loon, Albany; C. A. Ward, Binghamton; D. G. Wilcox, Buffalo; H. C. Allen, Chicago; H. P. Biggar, Cleveland; Frederick Kooker, Syracuse; L. C. Crowell, Syracuse.

Oregon State Medical Society.—The new officers of the Oregon State Medical Society elected September 11, 1902, are as follows: *President*, Dr. Henry Waldo Coe, Portland; *First Vice-President*, Dr. F. W. Van Dyke, Grant's Pass; *Second Vice-President*, Dr. J. A. Geisendorfer, The Dalles; *Third Vice-President*, Dr. J. P. Tamiesie, Hillsboro; *Secretary*, Dr. A. D. Mackenzie, Portland; *Treasurer*, Dr. Mae Cardwell, Portland; *Councilors*,

Drs. W. J. May, Baker City; J. Fulton, Astoria; Wm. Amos, Portland; G. F. Wilson, Portland; C. S. White, Gervais; S. T. Linklater, Hillsboro; W. T. Williamson, Salem; Wm. House, Pendleton; Ellis, Portland; R. C. Coffey, Portland.

The Northern Indiana and Southern Michigan Homœopathic Medical Association.—The twenty-third semi-annual meeting was held in the Council Chambers of the City Hall, Elkhart, Indiana, Tuesday, October 7, 1902.

The following physicians were the Chairmen of Bureaus: Surgery, Dr. A. S. Hewitt; Ophthalmology and Otology, Dr. C. D. Goodrich; Materia Medica, Dr. F. A. Benham; Practice, Dr. W. I. Tyler; Gynecology and Obstetrics, Dr. A. O. Ulrey; Pædiatrics, Dr. Carrie B. Banning.

A special effort was made to have a large attendance, which was successful, and the meeting was a grand success.

H. A. Mumaw, M.D.,
Secretary.

The Cincinnati Homœopathic Lyceum.—The Cincinnati Homœopathic Lyceum announces the following program for the winter of 1902-1903. The meetings will be held at the Pulte Medical College on the second Wednesday of each month, promptly at 8.45 P.M.:

October 8th.—President's Address, Dr. C. A. Pauly; "Neurasthenia," Dr. W. A. Geohegan; "The Physiological Factor in Diagnosis," Dr. A. L. McCormick; "Clinical Cases," Dr. F. W. Fishbach, Dr. Henry Snow.

November 12th.—"Neuroses vs. Psychoses," Dr. J. D. Buck; "X-Ray Therapy," Dr. H. H. Wiggers; "Ideas from New York Hospitals," Dr. F. W. Fischer; "Clinical Cases," Dr. Lincoln Phillips.

December 10th.—"Therapeutics of Cystitis," Dr. C. N. Cooper; "Acute Otitis Media and Acute Mastoiditis," Dr. Thos. M. Stewart; "Clinical Cases," Dr. S. R. Geiser, Dr. Ella G. Hunt.

January 14th.—"Suggestive Therapeutics," Dr. C. D. Crank; "Unusual Labor Cases," Dr. W. H. Smith; "Clinical Cases," Dr. Ellen M. Kirk, Dr. C. C. Meade.

February 11th.—"Adenoids," Dr. R. G. Reed; "Interesting Case from a Pathological Point of View, with Slides," Dr. L. D. Meader; "Clinical Cases," Dr. W. F. Reilly, Dr. W. G. Hier.

March 11th.—"Why We Suffer," Dr. Laura C. Brickley; "Pathological Surprises," Dr. C. E. Walton; "Clinical Cases," Dr. Chas. Zurmahlen, Dr. C. A. Pauly.

Miami Valley Homœopathic Medical Society.—The eighty-fourth semi-annual session of the Miami Valley Homœopathic Medical Society was held at the Algonquin, Dayton, Ohio, Thursday, October 30, 1902, for discussion of topics of interest to the profession. The officers of the Society are: *President*, T. A. McCann; *Vice-President*, E. B. Doan; *Treasurer*, W. H. Webster; *Secretary*, W. Webster Eusey; *Censors*, J. Tressler Ellis, J. E. Welliver and R. B. House.

The programme included the following:

"The Causes of Our Successes and Failures," by A. E. Goldsmith, M.D., Greenfield, Ohio. "Physicians' Bills and Collections," by Harry J. Guy, M.D., Dayton, Ohio. "Neurasthenia," by M. P. Hunt, M.D., Columbus, Ohio. "Treatment and Cure of Varicose Ulcers," by H. H. Herman, M.D., Dayton, Ohio. "Some Skin Cases from a City Clinic," by P. T. Kilgour, M.D., College Hill, Ohio. "Some Official Facts," by J. W. Means, M.D., Troy, Ohio. "The Feeding of Typhoid Fever Cases," by C. O. Munns, M.D.,

Oxford, Ohio. "Pack the Uterus with Gauze After Delivery, but Do Not Tie the Cord," by S. J. D. Meade, M.D., Cincinnati, Ohio. "A Post-Mortem, and How it Sustained the Doctor's Diagnosis" (with Slides), by Lee Douglass Meader, M.D., Cincinnati, Ohio. "The Modern Physician," by T. L. Laughlin, M.D., Dayton, Ohio. "Small-Pox," by H. R. Hawkins, M.D., Xenia, Ohio.

All the essays read evoked spirited discussion, and the meeting was of great profit to all who attended. The special discussion of photo-therapy, including the X-ray and the ultra-violet ray in the treatment of malignant growths, was exceedingly interesting.

The following officers were elected for the ensuing year: *President*, Dr. C. O. Munns, Oxford. *Vice-President*, Dr. Mark Pardee, Franklin. *Treasurer*, Dr. Ira J. Herr, Dayton. *Secretary*, Dr. W. Webster Ensey, Dayton.

The President appointed the following Legislative Committee: Drs. J. W. Means, Troy, O.; M. P. Hunt, Columbus, O.; H. E. Beebe, Sidney, O. Drs. George W. Miller, Dayton, O.; Frank Webster, Dayton, O.; and J. M. Wine, Dayton, O., compose the Executive Committee. The Board of Censors remains the same as last year. Dr. Frank Wilson, of Jeffersonville, O., was elected a member of the Society.

This Society continues to maintain its reputation for energy and progressiveness. The next meeting will be held at Dayton, O., the last Thursday in April, 1903.

The following were present: Wm. L. Brown, Lebanon, O.; W. J. Blackburn, Dayton; C. R. Coffeen, Piqua; J. H. Cook, New Carlisle, O.; C. N. Cooper, Cincinnati, O.; H. Wilgus Dickinson, Dayton; E. B. Doan, Miamisburg; W. Webster Ensey, Dayton; J. A. Ferree, Sidney; C. F. Ginn, Miamisburg; George D. Grant, Springfield; H. J. Guy, Dayton; C. M. Ginn, Dayton; C. E. Hauver, Greenville; I. J. Herr, Dayton; H. H. Herman, Dayton; J. W. Means, Troy; C. O. Munns, Oxford; T. A. McCann, Dayton; S. J. D. Meade, Cincinnati; Frank Murphy, Dayton; J. W. Overpeck, Hamilton; Mark Pardee, Franklin; A. S. Rosenberger, Covington, Ohio; W. C. Stubbs, Celina; J. E. Welliver, Dayton; J. M. Wine, Dayton; Harry S. Wetzel, Dayton; L. C. Walker, Jamestown; Frank Webster, Dayton; L. R. Pryor, Eaton; Charles J. Krehbiel, Dayton; J. H. Wilson, Bellefontaine; Geo. W. Miller, Dayton; H. E. Palmer, Dayton; E. B. Grosvenor, Richmond, Ind.

The visitors were: E. O. Willoughby, Dayton, and Frank Wilson, Jeffersonville.

Philadelphia County Homœopathic Medical Society.—The clinical amphitheatre of the Hahnemann Hospital was crowded to the doors on the evening of Thursday, November 13th, in response to the invitation extended by the County Society to the members of the profession to attend a post-graduate clinic by Dr. L. T. Ashcraft. In the course of two hours Dr. Ashcraft, assisted by Drs. Hunsicker, Douglas, Abele and Dalsimer, demonstrated nearly forty cases, illustrating every phase and complication of specific urethritis, its diagnosis and its treatment, together with the lesions, early and late, of syphilis. The wealth of material and the manner of its presentation aroused great enthusiasm on the part of the hundreds of physicians present.

The William B. Van Lennep Clinical Club held its regular meeting on the evening of November 4th at the residence of Dr. F. Mortimer Lawrence, 1601 Girard Avenue. A paper was presented by Dr. John J. Tuller, in which he took up the pathology of tabes dorsalis, and strongly antagonized,

on the ground of pathologic dissimilarity, the current belief in its syphilitic origin. Dr. F. Mortimer Lawrence discussed "The Clinical Evidences of Pulmonary Tuberculosis," and demonstrated, by a statistical study of the cases presenting themselves in the medical department of the Hahnemann Hospital Dispensary, the absolute divergence between symptoms and physical conditions. An active discussion of the two papers was followed by the customary luncheon.

The Saturday-Night Club of Microscopists resumed its monthly meetings, after the summer intermission, by assembling at the usual meeting-place at the Hahnemann Medical College, at 8.30 P.M., on October 18, 1902. President Dr. J. C. Guernsey in the chair.

Dr. R. J. McNeil, Dr. Russell Bibighaus, Dr. Philip Hoffman and Dr. Leroy Walker were proposed for membership. The resignation of Dr. Nathan Smilie was accepted, with a vote of thanks to Dr. Smilie for his efficient services during several years past.

The Executive Committee reported a plan for scientific work for the coming winter, whereby three short papers would be presented at each meeting.

Dr. S. W. Sappington gave a demonstration of the Wright blood stain, and exhibited a number of specimens showing its utility. Dr. D. Roman read a paper on "Intestinal Neoplasms, with Special Reference to Carcinoma," and exhibited microscopic slides from a case. Dr. Korndorfer, Jr., presented a series of nine microscopic slides for the cabinet of the society from a case of atalectasis in a child twelve hours old. After discussion of the above subjects, the society adjourned.

Theodore J. Gramm, M.D.,

Secretary pro tem.

Germantown Club.—The monthly meeting of the Germantown Homœopathic Medical Society of Philadelphia was held in the Odd Fellows' Temple on the evening of October 20th. There was a full attendance: and a résumé of recent advances in medicine, presented by Dr. George H. Bickley, elicited a spirited discussion.

Personals.—Dr. J. W. Dowling, Professor of Practice of Medicine in the New York Homœopathic Medical College, has been compelled by ill-health to temporarily relinquish his practice and leave the city. In his absence, his office, at 116 West Forty-eighth Street, will be in charge of Dr. LeRoy R. Stoddard.

Dr. L. T. Ashcraft announces a removal to rooms 700-706 Professional Building, 1833 Chestnut Street. Hours: 9 to 11 A.M., and by appointment. Telephone, 1-51-26.

Dr. Woodward D. Carter has removed to his new home, at 1311 South Broad Street, Philadelphia.

Dr. G. A. Van Lennep has returned from a rather extended visit to European clinics, and will open offices in the Professional Building, 1833 Chestnut Street.

Dr. J. Dean Elliott, having completed his term of service in the Pittsburg Homœopathic Hospital, has returned to Philadelphia, and will spend the coming year in the office of Dr. Wm. B. Van Lennep.

Dr. Hugh B. Barclay has opened an office in Greensburg, Pa. Hours: until 10 A.M., 1 to 2 P.M., 7 to 8.30 P.M. Telephone.

Dr. Geo. T. Barry has removed to 1637 Chicago Avenue, Evanston, Ill.

Dr. Wm. F. Satchell is located at 344 North 52d Street, Philadelphia.

Dr. F. C. Hutton is established at 660 East Allegheny Avenue, Philadelphia. Hours: 8 to 11 A.M., 6 to 7.30 P.M.; Sundays, 8 to 10 A.M. Telephone, 5-36-77 a.

Dr. D. W. Ensminger has opened an office in Mount Aetna, Berks Co., Pa.

Dr. Perry Dickie, 17 Schermerhorn Street, Brooklyn, N. Y., will, in the future, devote his attention exclusively to diseases of the ear.

Dr. Laird has removed his office to his residence, 643 S. Burlington Avenue, Los Angeles, Cal., where he will see patients on and after September 1, 1902. Telephone, Peter, 3786.

Dr. Scott Parsons, of St. Louis, announces that from September 1, 1902, he will discontinue general practice, and devote his time to general and gynecic surgery exclusively. Office, 3131 Washington Avenue. Hours: 11 to 1, and by appointment. Phones: Bell, Lindell 589 a; Kinloch, C 712.

Dr. Thomas D. Clegg has removed to 405 N. 54th Street, Philadelphia.

Dr. Alfred S. Mattson, of Moorestown, N. J., has removed to 1026 S. 32d Street. Office in the Bee Building, Omaha, Nebraska.

A silver loving-cup was given to Dr. T. Griswold Comstock, of St. Louis, Mo., by his fellow-homœopathic physicians, about fifty of whom visited him without warning at his home September 18, 1902. Dr. Comstock recently returned from the East. Dr. James A. Campbell, in presenting the cup, dwelt on the fact that Dr. Comstock was graduated at Philadelphia in 1853, and from the University of Vienna in 1857, but got his start in the old Jesuit College, in St. Louis, at Tenth Street and Washington Avenue. Dr. David N. Gibson offered poetic sentiments, and then, as the loving-cup was passed around, each guest said a few kind words. Dr. Comstock, in responding, referred to the motto, "Qui non proficit deficit," and touched on the progress of homœopathy.

For Sale or Exchange.—A practice of about \$3000 per year, including position as physician to cotton mill which pays \$20 to \$25 per month, in a city of 12,000 people. Full description given on application. A. O. Buck, M.D., Corsicana, Texas.

Obituary.—On November 9, 1902, Dr. A. W. Woodward, late Professor of Materia Medica and Clinical Therapeutics in the Chicago Homœopathic Medical College, and recently holding a similar position in the Hahnemann Medical College of Chicago, succumbed to Bright's disease. Dr. Woodward was graduated from Hahnemann College (Chicago) in 1862, and has for years held high rank as a teacher. His work on "Constitutional Therapeutics," representing twenty years of labor, is just passing through the press, and will shortly be issued.

Dr. R. N. Tooker, late Professor of Children's Diseases in the Chicago Homœopathic Medical College, who had been for many years associated with Dr. Woodward in that faculty, and who, with the latter, recently joined the staff of Hahnemann Medical College, also died on November 9, 1902. Dr. Tooker graduated from Bellevue Medical College, New York, in 1865, and had been for many years prominently identified with medical education in Chicago. In addition to his many contributions to periodical literature, he was the author of a widely-known work on "Pediatrics."

The Raue Medical Club.—The Raue Medical Club of Blair County held its twentieth regular monthly meeting September 16th, at the residence of Dr. E. H. Morrow, in Altoona.

The meeting was called to order at 3.30 P.M., Dr. Morrow in the chair. The following members were present: Drs. Morrow, Baker, Blackburn, Taylor, Bohn, Wrigley, and Hoy, of Altoona, and Stitzel and Humes, of Hollidaysburg. A paper was read by Dr. E. H. Morrow on "Normal Labor," and was followed by an interesting discussion, in which all present took part.

Daniel Bohn, M.D.,

Secretary.

New York Letter.—Dr. B. G. Clark has removed to 25 West 74th Street.

Dr. A. B. Norton has resumed work at his office, 16 West 45th Street.

Dr. George W. McDowell, of 542 Fifth Ave., returned September 15th.

Dr. Walter Sands Mills may be found, as formerly, at 154 West 119th St.; hours, 11-1, 6-7.

Dr. Edwin Brown Jenks is located at 134 East 70th Street.

Dr. Philip Cook Thomas has removed to 243 West 99th Street.

Dr. H. Everett Russell has resumed his New York practice at 30 East 74th Street.

Dr. E. Baruch has returned from Europe and resumed his practice.

Dr. Charles Deady announces his removal, October 1st, to No. 151 West 73d Street. Hours, 9-1, Sundays excepted, and by appointment. Eye, ear, and naso-pharynx.

Dr. Wm. H. Van Den Burg has returned to town and announces his office hours hereafter from 9 to 12 A.M.; Sundays, 12.30 to 1.30 P.M. 32 West 49th Street.

The Board of Trustees and Faculty of the New York Homœopathic Medical College and Hospital issued invitations to the opening exercises of September 30th, which were well attended. A large Freshman class has already matriculated.

The 1902 Directory of the Alumni of the New York Homœopathic Medical College and Hospital is issued in handsome form.

The Auxiliary Board of the Metropolitan Hospital has received three new appointments—Drs. F. Olin Hardy, John Hutchinson, George E. Morgan.

Dr. C. E. Teets, laryngologist of the Metropolitan Hospital, has resigned, and Dr. A. W. Palmer is elected to the vacancy.

The Homœopathic Medical Society of the County of New York held a regular meeting at Carnegie Hall Chapter Room, October 9th, with the following program:

Committee on Surgery.—Wm. F. Honan, M.D., *Chairman*. "Conservative Methods, with Special Reference to the Medicated Galvanic Current in the Treatment of Tubercular Glands, Goitre, and Uterine Fibroids, with Suggestions for the Treatment of Prostatic Hypertrophy," M. O. Terry, M.D., *Ex-Surgeon-General*, N. Y., etc. Discussion by Drs. Bukk G. Carleton, W. H. Dieffenbach, Clinton L. Bagg, Wm. Harvey King and Edward G. Tuttle.

Committee on Obstetrics.—Edward P. Swift, M.D., *Chairman*. "The Immediate Repair of the Cervix," Anna F. Donoghue, M.D. Discussion opened by Dr. Elizabeth Jarrett.

Committee on Materia Medica.—J. B. Garrison, M.D., *Chairman*. "Homœopathic Treatment of Glandular Enlargements," Walter Sands Mills, M.D. Discussion opened by Dr. Edmund Carleton.

The New York Homœopathic Materia Medica Society met on October 15th, at the residence of its President, W. S. Mills, M.D., 154 West 119th Street. At this meeting considerable interest was manifested in the future work of the society. Dr. M. W. Vandenburg, who has devoted much attention to the literature of our Materia Medica, and is an author in this field, presented an outline providing for the verification by members of recorded symptoms of well-known and well-proven drugs. Dr. C. C. Howard and other speakers discussed the plan, and a schema was laid down by which a working system becomes immediately practicable.

A regular meeting of the Academy of Pathological Science was held on Friday evening, October 24th, at the residence of Dr. S. Carleton, 62 West Forty-ninth Street. Drs. E. Carleton, G. F. Laidlaw, G. W. Roberts, B. H. Sleght and J. E. Wilson presented specimens and introduced subjects for discussion.

Dr. Caleb Barker has located at 126 West Ninety-third Street, Tel. 844 Riverside.

Dr. James Robie Wood, after many years of faithful service, has resigned from the medical board of the Metropolitan Hospital. Dr. H. L. Hathaway, of the auxiliary board, has been elected to fill the vacancy.

Dr. G. F. Laidlaw has resigned, and Dr. J. N. Ricardo succeeds him as pathologist at the Metropolitan.

The County Society met on Thursday evening, Nov. 13th. Candidates elected to membership were Dr. Thos. W. Embley, 314 East Eighteenth Street, and Dr. Frank M. Hallock, 134 West Sixty-fifth Street. Corresponding members elected were Dr. C. C. Clark, West Hoboken, N. J., and Dr. Fannie H. Kellogg, New Rochelle, N. Y. Nominations of candidates were made for election in December.

Report of the Necrologist.—John Hutchinson, M.D., in memory of Martin Deschere, M.D., and Margaret Whittemore, M.D. Special memorial committee in memory of Martin Deschere, M.D., Drs. H. M. Dearborn, A. Berghaus, and J. T. Simonson. Special memorial committee in memory of Margaret Whittemore, M.D., Drs. K. G. Townsend, M. B. Brown and E. Edmonston.

Committee on Materia Medica.—J. B. Garrison, M.D., *Chairman*. "The Zymoses and the Relation of Similia to Them," W. S. Searle, M.D., of Brooklyn. Discussion opened by Dr. Vandenburg, of Mt. Vernon, and Dr. Rushmore, of Plainfield.

Committee on Diseases of the Eye and Ear.—H. Cooley Palmer, M.D., *Chairman*. "Trachoma in the Public Schools," Charles H. Helfrich, M.D. Discussion by Dr. Geo. A. Shepard, Dr. Jarrett, Dr. Norton, Dr. Hallett.

Committee on Diseases of Women and Children.—M. Belle Brown, M.D., *Chairman*. "A Clinical Case Demonstrating Reflexes," Sophia Morgenthau, M.D. Discussion opened by Geo. W. Roberts, M.D., and Dr. E. D. Simpson.

Committee on Nominations.—F. E. Doughty, M.D., *Chairman*. Making nominations of officers for the election at the annual meeting, December 11th, reported as follows:

For *President*, Dr. Irving Townsend. *Vice-President*, Dr. Wm. Tod Helmut. *Secretary*, Dr. Walter Sands Mills. *Treasurer*, Dr. E. D. Munson. *Necrologist*, Dr. John Hutchinson. *Censors*, Dr. W. H. Vandenburg, Dr. Edmund Carleton, Dr. J. Perry Seward, Dr. Elizabeth Jarrett, Dr. Sophia Morgenthau, Dr. E. D. Rudderow, Dr. E. D. Simpson, Dr. Bukk G. Carleton.

John Hutchinson, M.D.

Washington Letter.—The Washington Homœopathic Medical Society held its regular monthly meeting at the Arlington Hotel on November 4th. After transacting some routine business, the Secretary, Dr. Taylor, gave out the programme for the annual meeting, to be held on the evenings of December 5th and 6th, which is to consist of three papers on each evening; the first evening to be devoted to Practice of Medicine and Therapeutics: papers to be read by Drs. S. S. Stearns, J. B. G. Custis, and M. M. Moffitt. On the second evening papers are to be read by Dr. George W. Roberts, of New York City, on "Cancer;" Drs. Gardner and Hawxhurst on "Roentgen Ray Therapy," and Dr. L. J. Barker on the "Newer Methods of Treatment for Hay Fever." Following this the evening was devoted to "Enteric Fever," papers being presented by Drs. S. S. Stearns, T. L. MacDonald and J. H. Branson.

Dr. Ralph Jenkins has resigned from the surgical staff of the National Homœopathic Hospital, and announces his intention to retire from practice, having become engaged in the brokerage business, and identified himself with the firm of Jenkins & Simpson, 1329 T St., N. W.

Dr. Waterman D. Corey is seriously ill at his home, 1095 R St., N. W.

Dr. C. L. Bliss has been appointed to the Orthopedic Department of the National Homœopathic Hospital, vice Dr. Ralph Jenkins, resigned.

Dr. Z. B. Babbitt is in New York City on business.

Dr. M. A. Brosius has returned to the city, and removed his office to The Cumberland, on Thomas Circle.

Dr. Herbert Bishop has returned from New York Post-Graduate School, again entering private practice here.

Navy Medical Estimates, 1903-4.—The Secretary of the Navy has presented his estimates for the support of the naval establishment during the fiscal year ending June 30, 1904. For the Bureau of Medicine and Surgery, \$485,000 is requested, an increase of \$175,000 over the amount given by Congress for the present year.

Small-Pox in the United States.—According to the U. S. official reports from June 28th to Oct. 10th there were 7608 cases and 436 deaths, as against 12,390 cases and 298 deaths for corresponding period in 1901.

Interne Wanted.—Examinations will be held December 9th for the position of medical interne at the Government Hospital for the Insane at Washington, D. C. Salary to be \$600 per annum. Applicants must be graduates of some reputable medical college.

Episcopal Eye, Ear and Throat Hospital of Washington.—A new building with frontage of 57 feet and a depth of 112 feet will be added to this institution. The ground has been purchased and more than \$11,000 subscribed and paid in to the treasurer of the building fund. Building operations will be commenced as soon as the required additional funds are subscribed.

Lack of Army Surgeons.—The Board in session at Washington has examined a large number of applicants for the forty vacancies that exist in the grade of assistant surgeon, but only five have been selected. The examinations are said to be so severe that only a young physician far above the average can pass successfully, and unfortunately there are few inducements for this class to apply for the positions, the pay of the new assistant surgeon being only \$1600 per annum, with slow advancement. This explains the reason why so many of the better men prefer the quiet routine of general practice to that of work in connection with the Army Medical Corps.

Government Insane Hospital Report.—The forty-seventh annual report of the Board of Visitors of the Government Hospital for the Insane to the Secretary of the Interior has been completed. The report is signed by Dr. Frank M. Gunnell, the President of the Board, and Dr. A. B. Richardson, the Superintendent of the Hospital, as Secretary. The report says, among other things:

"The admissions for the year were 686, the largest number in the history of the hospital. Of these, 297 were from the Army, Navy and Marine-Hospital Service, and 389 from civil life. Of the latter, 285 were cases of indigent patients residents of the District of Columbia, and 51 were non-residents admitted by order of the District Courts. The recoveries number 248, or 36.15 per cent. of the admissions. The deaths were 177, which is 6.18 per cent. of the whole number under treatment, and 8.06 per cent. of the average number resident.

"The health of the inmates has been good during the year, with the exception of a few cases of typhoid fever during the fall months of 1901.

"The appropriations recommended for the hospital for 1903-1904 are as follows: For support, maintenance, etc., of 2350 patients at \$220 per annum, \$517,000. On account of the many extra expenses that must necessarily be met from this fund, connected with the opening of the new buildings and the

transfer of patients, with the rearrangement of the entire system of administration, it is not believed to be wise to reduce this estimate.

"The repairs to the hospital will require the sum of \$25,000.

"The sum of \$6000 is requested with which to install a filtration system at the hospital, much of the drinking-water being drawn still from the river."

The report concludes with the following recommendation :

"This Board is also impressed with the necessity for amendment to the law regulating commitment to the hospital and the discharge of patients therefrom. It is particularly important that authority be given the superintendent to grant trial visits before discharge to such patients as are believed to be in a condition to warrant it, and also to discharge to the custody of friends such as can be safely cared for outside of a hospital, and who cannot be further benefited by hospital treatment."

Egyptian Medical Congress Representative.—Major William C. Gorgas, surgeon, U. S. A., has been designated by Surgeon-General O'Reilly to represent the United States Army at the first Egyptian Medical Congress, which will meet in Cairo, December 16th. The purpose of the Congress is to collect data in regard to tropical diseases and discuss means for eradicating them. Major Gorgas is an expert on tropical diseases. He was stationed at Havana during the greater part of the American occupation of Cuba, and made a special study of yellow fever. It was through his efforts that the disease was practically eradicated in Cuba. The great cholera epidemic in Egypt this summer was the main reason for the calling of the Congress.

Navy and Marine Corps, U. S. Army.—The first annual report of Surgeon-General Rixey shows that the percentage of sick and the death-rate for the past year was lower than for several years. An important feature of the report is the strong recommendation that a woman's nurse corps be introduced into the navy, and that Congress be asked to provide for the establishment of such a corps, which should consist of a superintendent nurse, 8 head nurses, 16 first-class and 24 second-class nurses, with the provision that these numbers are to be increased at the discretion of the Secretary. A strong plea is made for the appointment of dentists for the navy, as many otherwise good recruits are lost through lack of dental care. Attention is also called to the present entirely inadequate medical corps, and it is recommended that 150 additional medical officers be appointed, and that after each cruise surgeons be given a period of duty either at home or abroad in one of the great medical centres, where they can have an opportunity to keep abreast with medical progress. Other measures advocated in the report are the construction of two hospital ships, one for the Atlantic and one for the Pacific; the erection of a sanatorium for the treatment of pulmonary tuberculosis; improvement of sick quarters aboard ship; and the representation of the medical corps in the naval boards which design ships, so that sanitary conditions may be improved.

Macpherson Crichton, M.D.

Philadelphians Won Both Prizes.—The interest of the medical men throughout the country has for some time past centred in the two prizes of a thousand dollars and five hundred dollars which were offered by the Maltone Company last January for the two best essays on "Preventive Medicine." These prizes have just been awarded by the judges, Dr. Lewis, of New York, Dr. Reed, of Cincinnati, and Dr. Rhodes, of Chicago, who met for a final consultation in Buffalo. Two hundred and nine essays were submitted in competition, and, although nearly every State in the Union was represented in the contest, *both prizes were won by Philadelphia men.* The thousand dollar

prize was awarded to Dr. W. Wayne Babcock, 3302 North Broad Street, Philadelphia. His essay is entitled "The General Principles of Preventive Medicine," and was submitted under the *nom-de-plume* "Alexine." The five hundred dollar prize was awarded to Dr. Lewis S. Somers, 3334 North Broad Street, Philadelphia. His essay is entitled "The Medical Inspection of Schools—A Problem in Preventive Medicine," and was submitted under the *nom-de-plume* "Broad."

The two successful essays will first be published in representative medical journals, and then in permanent form for gratuitous distribution to the profession at large. In addition to the benefit to medical science derived through the result of the contest, Philadelphia physicians will rejoice in this latest evidence that their city is now, as for a century past, the centre for all that is best in American medicine.

State Board of Medical Examiners of New Jersey.—At a meeting of the State Board of Medical Examiners of New Jersey, held at Newark, N. J., October 1st, twenty-three of the twenty-eight physicians who took the State examination held at Trenton, N. J., September 16, 17, were duly licensed to practice medicine in New Jersey.

The following medical colleges were represented by the candidates :

Baltimore Medical College,	3
College of Physicians and Surgeons of Baltimore,	3
Columbia University, Medical Department,	3
Baltimore University, School of Medicine,	2
Hahnemann Medical College and Hospital of Phila.,	2
Jefferson Medical College,	2
University of Naples, Italy,	2
Boston University, School of Medicine,	1
Columbian University, Medical Department,	1
Dartmouth Medical College,	1
Medico-Chirurgical College of Philadelphia,	1
Shaw University, Medical Department,	1
University of Montpellier, France,	1
University of the South, Medical Department,	1
University of Turin, Italy,	1
University of Vermont, Medical Department,	1
Woman's Medical College of Pennsylvania,	1
Yale University, Medical Department,	1

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The percentage of rejections for the September examination was eighteen.

Beginning with the examination in June, 1903, each applicant for examination will be required to file with his application a recent photograph of himself, with autograph signature, duly attested before and under the seal of a Notary.

In the matter of interstate reciprocity of medical license, the policy of the Board in endorsing the licenses issued by other States whose examining requirements are substantially the same as those of New Jersey, provided that the applicant fully meets the academic and medical requirements of the State, is gaining favor both with the profession and other State Boards. This policy places the admission of an applicant upon the basis of his personal fitness and the thoroughness of his examination, which is believed to be the fairest and most equitable method of endorsement so far devised.

A Chair of Homœopathy in a German University.—According to the *Gazette Medicale de Paris* for September 27th, the two Bavarian Chambers have agreed to the creation of a Chair of Homœopathy at the University of Würzburg.

Membranous Complications.—Under the above heading we find the following by Walter M. Fleming, A.M., M.D., New York City, in the September number of *The Medical Era*: "With all the experience of more than a quarter of a century in the treatment of winter cough and its complications of laryngeal, bronchial and pulmonary irritability, also dyspnoea, asthmatic spasms, and finally whooping-cough—usually the most persistent and tenacious of all of these membranous maladies—I find no one remedy more strongly indicated, or which yields more prompt and satisfactory results, than antikamnia and heroin tablets, composed of antikamnia 5 grains and heroin hydrochloride $\frac{1}{2}$ grain. The purpose of this combination is manifest at once, for it provides, primarily, a respiratory stimulant; secondly, a soothing sedative to the irritable mucous membrane; and, thirdly, an antipyretic and analgesic. Result: A prompt and efficient expectorant, which at once relaxes the harsh and rasping cough, and releases the tenacious, sticky and gelatinous mucus, while its soothing influence is at once manifested, greatly to the comfort and contentment of the patient."

So-called "Christian Science."—While it is totally incomprehensible to the practical, hard-headed, common-sense individual, that any one should pursue such an intangible chimera as "Christian Science" with such sublime faith as to depend upon it in the presence of serious bodily illness, certain it is that the disciples of this vicious religious monomania are increasing in number and temporal power, and that it is no longer safe to entirely ignore it as a menace to the health and well-being of the community. Both the medical and secular press have devoted considerable attention to the subject, largely in the way of ridicule, but the most powerful, logical, and altogether unanswerable argument we have yet seen is comprised in a series of short lectures by Rev. Andrew F. Underhill, of St. John's Episcopal Church, Yonkers, N. Y., entitled "Valid Objections to So-called Christian Science." Realizing that their interests are identical with those of the medical profession, and that the enemy of one is the enemy of both, The Arlington Chemical Co. is anxious to do its part in relegating this absurd cult to the limbo of oblivion, where it may rest peacefully side by side with the many foolish fads that have preceded it.

Appreciating the force of the argument referred to, and being convinced that it will place in the hands of the physician a well-forged weapon wherewith to combat such a subtle and dangerous enemy, The Arlington Chemical Co. has obtained the permission of the author to reprint these lectures in booklet form and distribute them to physicians. If any of our readers have been overlooked in the mailing, a request to the above Company will bring a copy.

A Tribute to Passiflora.—I have used Daniel's conc. tr. passiflora incarnata in practice, with good results. Passiflora has a wide field of usefulness, but my especial experience with it has been in insomnia and neurasthenia, where it has proven very valuable.

(Signed), J. P. Thorn, M.D.,
Jonesville, Wis.

The American Pharmaceutical Association, appreciating the superior quality of G. H. Mumm & Co.'s Extra Dry Champagne, used that brand exclusively at the banquet in celebration of their 50th anniversary, held at Horticultural Hall, Philadelphia, Thursday evening, September 11th. This was certainly a high testimonial to Mumm's, and is the more significant because none, except, of course, physicians, know so well as the pharmacists the importance of selecting a good champagne for use in sickness or in health.

